

November 8, 2002

HEALTH and COMMUNITY SUPPORTS CONTRACT

between

DEPARTMENT OF HEALTH
AND FAMILY SERVICES

and

«County» COUNTY

January 1, 2003 – December 31, 2003

Health and Community Supports Contract
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Health and Community Supports Contract¹

between

Department of Health and Family Services

and

«County» County

This contract is entered into for the period January 1, 2003 to December 31, 2003 by the Department of Health and Family Services, hereafter DHFS, whose principal business address is One West Wilson Street, P.O. Box 7805, Madison, Wisconsin, 53707-7850, and «County» County's Care Management Organization demonstration project, hereafter CMO, whose principal business address is «Department», «Address».

Whereas, DHFS wishes to purchase certain long-term care and health care services, under the State Medicaid Plan approved by the Secretary of the U.S. Department of Health and Human Services pursuant to the Social Security Act, and as authorized by Section 46.284(2) of the Wisconsin Statutes.

The CMO is an organization certified by DHFS, pursuant to Section 46.284(3) of the Wisconsin Statutes, to make available to members, in consideration of periodic fixed payments, certain long-term care and health care services.

Now, therefore, DHFS and CMO agree as follows:

I. CMO Governance and Consumer and Member Involvement

A. CMO Governing Board

The CMO shall have a governing board that meets the following specifications:

1. *Diversity*

The board shall reflect the ethnic and economic diversity of the CMO service area.

2. *Consumer Representation*

At least one-fourth of the members of the board shall be older persons or persons with physical or developmental disabilities or their family members, guardians or other advocates who are representative of the CMO's members.

¹ Definition of terms used in this contract are contained in Addendum I, page 105.

3. *Separation from Eligibility/Enrollment*

The CMO will assure the CMO's separation from the eligibility determination and enrollment counseling functions. The separation shall meet criteria established by DHFS in accordance with section 46.285 of the Wisconsin Statutes and applicable Federal guidelines.

4. *Family Care District*

If the CMO is operated by a Family Care district, as described in s. 46.2895 Wis. Stats., the district shall meet the requirements for governance in s. 46.2895 Wis. Stats.

B. Local Long-Term Care Council

The Local Long-Term Care Council (LLTCC) is responsible for general planning and oversight functions which are specified in s. 46.282 (3) Wis. Stat. The CMO shall cooperate with and provide assistance to the LLTCC to successfully complete LLTCC duties. At a minimum, the CMO shall perform the following:

1. *Information from the CMO*

The CMO shall provide the LLTCC with information on appeals and grievances, enrollments and disenrollments, agreements and memorandums of understanding related to eligibility and enrollment functions, provider networks, and service utilization.

2. *Recommendations from the LLTCC*

The CMO shall receive and give consideration to the LLTCC's recommendations on the following:

- a. The CMO provider network in regard to developing a network of providers which is accessible, convenient and desirable;
- b. Any proposed changes to the Health and Community Services Contract;
- c. Whether to offer optional services which are provided through Medicaid fee-for-service (see Article III.A(5), *Services Coordinated Through Medicaid Fee-For-Service* (page 17), for the list of services) and strategies to offer such services if recommended;
- d. Strategies for improving interactions with any other agency related to eligibility and enrollment; and strategies for improving the CMO based on a review of the CMO Annual Appeal and Grievance Report.

II. CMO Functions: Enrollment and Disenrollment

A. Approval of Marketing/Outreach Plans and Materials

The CMO agrees to engage only in marketing/outreach activities that are pre-approved in writing, as follows:

1. *Initial Plan Approval by DHFS*

The CMO shall have a marketing/outreach plan approved in writing by DHFS by the effective date of this contract.

2. *Annual DHFS Review*

Annually, the CMO shall submit a marketing/outreach plan to DHFS and receive written approval before future contracts will take effect.

3. *DHFS Approval of Marketing Material*

The CMO shall submit to DHFS for approval all marketing/outreach materials, including mailings sent only to members, prior to disseminating the materials.

DHFS will review the marketing/outreach plan and materials as soon as possible, but within ten business days of receipt. Marketing/outreach materials are deemed approved if there is no response from DHFS within ten business days. However, problems and errors subsequently identified by DHFS, insofar as they pertain to the prohibited practices listed below, must be corrected by the CMO when they are identified.

Approval of marketing/outreach plans and materials will be reviewed by DHFS in a manner which does not unduly restrict or inhibit the CMO's marketing/outreach plans and materials, and which considers the entire content and use of the marketing/outreach materials and activities. Specific language approved by DHFS may be used again or in other media without being resubmitted for approval.

4. *CMO Operated by a County*

For any CMO operated by a county, all marketing and outreach materials must indicate that the CMO is a county agency and the county is also operating the Resource Center.

5. *Local Long-Term Care Council Review*

All marketing/outreach materials must be reviewed by the Local Long-Term Care Council (LLTCC) to assure materials are understandable and readable for the average consumer.

6. *Prohibited Practices*

The following marketing/outreach practices are prohibited:

- a. Practices that are discriminatory;
- b. Practices that seek to influence enrollment in conjunction with the sale of any other insurance product;
- c. Direct and indirect cold calls, either door-to-door or telephone;
- d. Offer of material or financial gain to potential members as an inducement to enroll;

- e. Activities and materials that could mislead, confuse or defraud consumers;
- f. Materials that contain false information;
- g. Practices that are reasonably expected to have the effect of denying or discouraging enrollment; and,
- h. Marketing/outreach activities that have not received written approval from DHFS.

7. *Marketing/Outreach Materials and Activities*

Marketing/outreach materials shall be distributed to all consumers eligible for the CMO in the service area. DHFS will determine what marketing/outreach materials and marketing/outreach activities are subject to the requirements of this contract.

B. Member Handbook

A member handbook shall be reviewed and approved using an internal CMO advisory body (as defined under Article III.E(2)(j), *Sensitivity to Population*, page 33).

1. *Required Information*

The handbook at a minimum will include information about:

- a. Being a member of the CMO. This information shall include the nature of membership in a Care Management Organization as compared to fee-for-service;
- b. Obtaining assistance for members with cognitive impairments to review materials about membership in the CMO;
- c. Location(s) of the CMO facility or facilities;
- d. Hours of service;
- e. Information on services in the LTC benefit package, including:
 - i. List of services in the LTC benefit package;
 - ii. Each member's right to select from the CMO's network of providers, and any restrictions on member rights in selecting providers;
 - iii. Ability to change providers;
 - iv. Any cost sharing related to these services; and,
 - v. The right of each member seeking residential services to request a private room and explanation of procedures to meet this request when a private room is not immediately available;

- f. Information on Medicaid covered services not in the LTC benefit package that remain fee-for-service and procedures for obtaining these services (for members who are Medicaid beneficiaries), including:
 - i. The list of these services;
 - ii. How and where to obtain these services;
 - iii. How transportation is provided; and,
 - iv. Any cost sharing related to these services.
- g. Provider network listing which includes:
 - i. Provider name (individual practitioner, or agency as appropriate);
 - ii. Provider location, and telephone number;
 - iii. Services furnished by the provider;
 - iv. Any known provider limitations in accepting new CMO members (if a preferred provider is not accepting new members, the CMO assist the member in obtaining an alternate provider.); and,
 - v. Accessibility of the provider's premises (if the member will be receiving services at the provider's premises).
- h. The right to receive services from culturally competent providers, and information about specific capacities of providers, such as languages spoken by staff, etc;
- i. Information on the extent to which members may obtain services outside of the provider network;
- j. Policies and procedures for advance authorization of services, and on the members' ability to obtain services necessary to achieve outcomes;
- k. Policies on use of after hours services and obtaining services out of the CMO's service area;
- l. Information on voluntary enrollment, voluntary disenrollment, and involuntary disenrollment;
- m. Members' rights and responsibilities as defined by DHFS;
- n. Information about independent advocacy services available as sources of advice, assistance and advocacy;

- o. Appeal and grievance process:
 - i. What constitutes an appeal, grievance, or fair hearing request;
 - ii. How to file appeals, grievances and fair hearing requests, including timeframes and the member's ability to appear in person before the CMO personnel assigned to resolve appeals and grievances;
 - iii. Information about the availability of assistance with the appeal and grievance process, and fair hearings;
 - iv. Toll-free numbers that the member can use to register a appeal or submit a written grievance by telephone;
 - v. Specific titles and telephone numbers of the CMO staff who have responsibility for the proper functioning of the process, and who have the authority to take or order corrective action;
 - vi. Assurance that filing an appeal or grievance or requesting a fair hearing process will not negatively impact the way the CMO, its providers, or DHFS treat the member; and,
 - vii. How to obtain services during the grievance and fair hearing processes.
 - p. Procedure for members to have input on changes in the CMO's policies and services;
 - q. Notice of right to obtain information on results of member surveys;
 - r. Information regarding estate recovery provisions applying to CMO membership;
 - s. If the CMO is operated by a county, indication that the CMO is a county agency and that the county also operates the Resource Center; and,
 - t. Information on the Family Care Member Outcome Interview process, including the possibility that the CMO will ask the member to participate.
2. *Annual Handbook Review*
The CMO shall have an updated member handbook approved by DHFS before the effective date of this contract.
3. *Handbook Updates*
The CMO shall provide members periodic updates to the member handbook as needed to explain changes in the above areas. Such changes must be approved by DHFS prior to distributing. Changes are considered approved if there is no response from DHFS within 10 business days. However, problems and errors subsequently identified by DHFS shall be corrected by the CMO.

4. *Notices About Provider Changes*

Notices about changes in providers that are to be sent to members and shared with the Resource Center must be submitted to DHFS for prior approval. DHFS will respond as soon as possible, but within 30 calendar days.

5. *Member Handbook Dissemination to Non-CMO Members*

The CMO shall provide the Resource Center and Enrollment Consultant with Department approved member handbooks for the purpose of dissemination to potential CMO members.

6. *Member Handbook Dissemination to CMO Members*

The CMO shall provide members a member handbook annually at a minimum.

C. Enrollment

The CMO shall comply with the following related to enrollment:

1. *Open Enrollment*

Conduct continuous enrollment consistent with the access plan approved by DHFS provided the individual meets eligibility requirements as defined in Addendum I, *Definitions* (page 105). Practices that are discriminatory or that could reasonably be expected to have the effect of denying or discouraging enrollment are prohibited.

2. *Voluntary Enrollment*

Enrollment in the CMO is voluntary.

3. *Enrollment While Eligibility is Pending*

The CMO shall have an MOU or other written agreement with the Resource Center that describes the circumstances in which the CMO will provide services to an individual who is functionally eligible but whose financial eligibility is pending, and that includes a process for the Resource Center to inform the individual that if he/she is determined not to be eligible, he/she will be liable for the cost of services provided by the CMO.

The CMO will not receive a per member per month payment for an individual during the time eligibility is pending. If and when eligibility is established, the CMO will receive a per member per month payment retroactively to the date indicated as the “effective date of enrollment” on the Enrollment Request form, or the Family Care eligibility certification start date, whichever is later, up to a maximum of 90 calendar days of serving the person while eligibility was pending.

If the individual is determined not to be eligible, the CMO may bill that individual for the services the CMO has provided. The CMO shall pay providers for services which were provided and prior authorized by the CMO. The CMO shall not require providers to collect payment from the individual. The CMO shall refer non-eligible individuals to the Resource Center for counseling about long-term care options.

The timelines for completion of the comprehensive assessment and Individual Service Plan (ISP) shall be based on the date eligibility is established, not on the date of enrollment. The initial ISP shall be developed by the CMO and signed by the individual receiving services within five business days of the date indicated as the “effective date of enrollment” on the Enrollment Request form.

D. ID Cards

1. MA Forward Card

Members enrolled in the CMO who are eligible for Medical Assistance will receive a Forward ID Card that will give providers information necessary to verify Medicaid and Family Care eligibility. The Department and the CMO will offer ongoing information to Medicaid certified providers about the Family Care initiative and services still available fee-for-service to Medicaid eligible members.

2. Non-MA Members

Members enrolled in the CMO who are not eligible for Medical Assistance will not receive a Forward ID Card.

E. Disenrollment

The CMO shall comply with the following related to disenrollment:

1. Voluntary Disenrollment

All members shall have the right to disenroll from the CMO without cause at any time. If the member expresses a desire to disenroll from the CMO, the CMO shall make a referral to the Resource Center for choice counseling with the member. The Resource Center will notify the CMO about the final disenrollment decision. The CMO shall continue providing services until the disenrollment date.

2. CMO Influence Prohibited

The CMO shall not counsel or otherwise influence a member due to his/her life situation (e.g. homelessness, increased need for supervision) or condition (e.g. person with profound mental retardation, person with AIDS) in such a way as to encourage disenrollment.

3. Ineligibility

The member will be disenrolled if he/she loses his/her eligibility. Loss of eligibility occurs when:

- a. The member fails to meet functional or financial eligibility requirements;
- b. The member initiates a move out of the CMO service area;
- c. The member fails to pay, or to make satisfactory arrangements to pay, any cost share amount due the CMO after a 30 calendar day grace period;
- d. The member dies; or,

- e. The member is ineligible for Medical Assistance as an Institutionalized Individual consistent with 42CFR435.1008 and as defined in 42CFR435.1009.
- 4. *Involuntary Disenrollment*

The CMO's intention to involuntarily disenroll a member shall be submitted to DHFS for a decision and shall be processed in accordance with Article IV.H, *Department Appeal and Grievance Resolution Process*, and/or Article IV.I, *Fair Hearing Process* (beginning on page 44). When the CMO submits a request for disenrollment to DHFS, the CMO shall also inform the member of the CMO's request for disenrollment and refer the member to the Resource Center for choice counseling and potential transition back to the fee-for-service system. The CMO shall continue to serve the member until the effective disenrollment date.
- 5. *Continuity of Services*
 - a. Until the date of disenrollment, members are required to continue using the CMO's providers for services in the LTC benefit package. The CMO shall continue to provide all needed services in the LTC benefit package until the date of disenrollment.
 - b. To facilitate a member's reinstatement in the fee-for-service system (for members who are Medicaid beneficiaries), the CMO shall assist the member in obtaining necessary transitional care through appropriate referrals and by making member records available to new providers.

F. Enrollment/Disenrollment, and Re-Enrollment Process

- 1. *Monitoring by DHFS*

The CMO shall permit DHFS to monitor enrollment and disenrollment practices of the CMO under this contract.
- 2. *Interactions with Other Agencies related to Eligibility and Enrollment*
 - a. The CMO shall fully cooperate with other agencies and personnel with responsibilities for eligibility determination, eligibility re-determination, and enrollment in the CMO. This includes but is not limited to the resource center, economic support and the enrollment consultant. The CMO shall participate with these agencies in the development and implementation of a plan that describes how the agencies will work together to assure accurate, efficient and timely eligibility determination and re-determination and enrollment in the CMO.
 - b. The CMO shall jointly develop with the resource center protocols for voluntary and involuntary disenrollments, per contract specifications.

- c. The CMO shall have an MOU or other written agreement with the resource center that describes the circumstances in which the CMO will provide services to an individual who is functionally eligible for the Family Care benefit but whose financial eligibility is pending, and that includes a process for the Resource Center to inform the individual that if the individual is determined not to be eligible, the individual will be liable for the cost of services provided by the CMO.

3. *Discriminatory Activities*

Enrollment continues as long as desired by the eligible member regardless of changes in life situation or condition, until the member voluntarily disenrolls, loses eligibility, or is involuntarily disenrolled according to terms of this contract. The CMO may not discriminate in enrollment and disenrollment activities between individuals on the basis of life situation, condition or need for long-term care or health care services. The CMO shall not discriminate against a member based on income, pay status, or any other factor not applied equally to all members, and not base requests for involuntary disenrollment on such grounds.

4. *Dates of Enrollment and Disenrollment*

- a. The CMO shall enroll and begin serving individuals as of the effective date of enrollment on the Enrollment Request form, or the Family Care eligibility certification start date, whichever is later. Enrollment dates will not be entered for dates more than 6 calendar months in the past unless an error was made by EDS or by the ES worker. If the CMO determines that it was an ES error a copy of the original enrollment form must be submitted to DHFS for review.
- b. A voluntary disenrollment shall be effective on the date indicated on the disenrollment form as effective disenrollment date.
- c. An involuntary disenrollment shall be effective on the date approved by DHFS as the disenrollment date. In order to allow time for the member to grieve an involuntary disenrollment decision from DHFS, DHFS shall retain the disenrollment form for 14 calendar days after the member has been notified by DHFS before forwarding it to the Medicaid fiscal agent or economic support worker to process the disenrollment. If the member files a grievance of an involuntary disenrollment decision to the fair hearing process within 14 calendar days, disenrollment shall be delayed until the grievance is resolved.
- d. If the member dies, the date of disenrollment shall be the date of death.
- e. Loss of eligibility resulting in disenrollment.

- i. If a CMO member is planning to or has moved out of the CMO service area, the CMO shall complete a Family Care CMO disenrollment form and send copies of the form to both the Resource Center and the Economic Support Unit. The date of disenrollment shall be the date the member moved out of the service area. The member's signature is not required on the enrollment form in this circumstance.
- ii. If a CMO member loses eligibility for a reason other than a move out of the service area, the last day of eligibility shall be set according to adverse action logic in CARES. The disenrollment date will be the date eligibility ends. The CMO shall continue to provide services to the member until the date of disenrollment.

5. *Re-enrollment*

In the case of voluntary disenrollment, the CMO shall allow an individual to re-enroll one time if the individual meets eligibility criteria. If the member voluntarily disenrolls for a second time, subsequent re-enrollments are at the discretion of the CMO. If the CMO chooses to consider subsequent re-enrollments, decisions shall be based on policies which do not discriminate based on cost, life situation, health status or condition. Prior to allowing individuals to re-enroll after two (2) or more voluntary disenrollments, the CMO shall have such policies approved by DHFS.

6. *Level of Care Re-determinations*

The CMO shall develop procedures to assure prompt administration of the LTCFS for members of the CMO which at a minimum shall include:

- a. The LTCFS will be conducted annually after enrollment by an individual trained and certified to administer the screen, and the member must receive an "intermediate" or "comprehensive" rating for continued enrollment in the MCO, unless the individual is eligible under the grandfathering criteria.
- b. The CMO may request a trained and certified screener to re-administer the LTCFS to re-evaluate the member's level of care rating, if the member's condition changes significantly.
- c. If the trained screener administering the LTCFS is an employee, or under direct supervision of the CMO, no Medicaid Administration reimbursement may be claimed for administration of the screen.

7. *Accuracy of Information*

The CMO shall not knowingly misrepresent or knowingly falsify any information on the LTCFS. The CMO shall also verify the information it obtains from or about the individual with the individual's medical, educational, and other records as appropriate to ensure its accuracy.

8. *Standards for Staff Qualifications*

The CMO shall ensure that staff members who administer the functional screen meet all qualifications to be members in CMO interdisciplinary teams.

In addition, individuals administering the LTCFS must pass the post test designed by the Department and shall be certified as a functional screener by the Department before being allowed to administer the functional screen on individuals.

9. *Policies and Procedures Concerning Functional Screen Quality*

The CMO shall develop and implement Department-approved policies and procedures to ensure the accuracy and timeliness of all of the functional screens done by the CMO or CMO contractors. These policies and procedures shall include provisions for the CMO to do at least all of the following:

- a. Designate a staff member who meets all of the requirements to administer the LTCFS to be a screen lead and have this screen lead do the following:
 - i. Act as the liaison between the Department and the CMO with respect to all of the issues involving the quality of the screens done by the CMO;
 - iii. Attend all of the screen lead meetings held by the Department; and,
 - iii. Randomly sample completed screens to make sure that they are accurate and complete.
- b. Have all of the screeners read and follow all of the instructions for the functional screen issued by the Department and all of the updates issued by the Department to these instructions;
- c. Train, mentor, and monitor new screeners;
- d. Work with the Department to maintain an accurate, complete, and up-to-date list of all of the staff members who are screeners;
- e. Consult with the Department about cases where it is proving unusually difficult for the CMO to complete an accurate screen on an individual or to interpret all or part of a completed screen;
- f. Have the screen lead and other screeners participate in all of the training on the screen that the Department requires them to participate in;
- g. Have all of the screeners complete at least once during the effective term of this contract the hypothetical case scenario exercise that the Department creates and implement any improvement projects or correction plans the Department requires to ensure the accuracy and thoroughness of the screens done by its screeners if the Department concludes, after reviewing the results of this exercise, that there are or may be problems in these areas and communicates this conclusion to it; and,

- h. Discuss with the Department what changes, if any, it might need to make in the way that it does its screening if the Department concludes, after analyzing data from screens that the CMO has done, that there are or may be problems with the way it is doing its screening and communicates this conclusion to it in the quarterly reports or in the annual report that the Department prepares on screen data and sends to the CMO or in any other way at any other time.

10. Department Deadlines for Submission and Approval

The CMO and the Department shall observe the following deadlines for the submission and approval of the Care Management Organization's policies and procedures concerning the quality of the screens that it does.

- a. The (CMO) shall submit these policies and procedures to the Department no later than January 15, 2003.
- b. No later than forty (40) calendar days after the (CMO) submits these policies and procedures, the Department shall review them and shall notify the CMO whether it approves them in whole or in part. If and when the Department notifies the Resource Center that it approves them in part, it shall also notify the Resource Center of the ways in which the Resource Center needs to change them to make them comply with the requirements of this contract.
- c. In the event that the Department does notify the CMO that the CMO needs to change these policies and procedures to make them comply with the requirements of this contract, the CMO shall resubmit them with the requested changes to the Department no later than fifteen (15) calendar days after being notified by the department of the need to change them. The Department shall notify the CMO whether it approves these policies and procedures with the requested changes no later than fifteen (15) calendar days after receiving them with the requested changes.

G. Pre-Existing Conditions

The CMO shall assume responsibility for all covered long-term care and medical conditions of each member as of the effective date of coverage under this contract.

III. CMO Functions: Services

Members shall be provided with high-quality long-term care and health care services that are from appropriate and qualified providers, that are fair and safe, that serve to maintain community connections, including work, and that are cost effective.

The CMO will inform members of the full range of services in the LTC benefit package. The CMO will provide a range of services to meet the needs and outcomes of its members, as identified in the comprehensive assessment process.

The CMO is not restricted to providing only the services in the LTC benefit package listed below. In developing service plans in consultation with members, member's authorized representatives and informal supports, the CMO interdisciplinary team may decide that other services, treatments or supports are more appropriate or likely to result in better outcomes than the services in the LTC benefit package (e.g., exceptional housing needs, acupuncture, membership in a fitness club). The per member per month payments made to the CMO will not be increased or decreased when additional or alternative services are provided.

Members shall receive services in the long-term care benefit package where they live, including:

1. Member's own home, including supported apartments.
2. Alternative residential settings:
 - State Certified Residential Care Apartment Complex (RCAC).
 - Community-Based Residential Facility (CBRF).
 - Adult and Family Homes.
3. Nursing Facilities or ICFs/MR.

The CMO shall provide support for self-directed care as described in this Article under B(2), *Self-Directed Supports* (page 21).

A. Provision of Services in the LTC Benefit Package

1. Services for Members at the Comprehensive Level

The CMO shall promptly provide or arrange for the provision of all services in the LTC benefit package, consistent with Individual Service Plan (ISP) which include:

- Adaptive Aids (general and vehicle) ¹
- Adult Day Care ¹
- Alcohol and Other Drug Abuse Day Treatment Services (in all settings) ²
- Alcohol and Other Drug Abuse Services, except those provided by a physician or on an inpatient basis ²
- Case Management (including Assessment and Case Planning) ^{1, 2}
- Communication Aids/Interpreter Services ¹
- Community Support Program ²
- Counseling and Therapeutic Resources ¹
- Daily Living Skills Training ¹
- Day Services/Treatment ¹
- Durable Medical Equipment, except for hearing aids and prosthetics (in all settings) ²
- Home Health ²
- Home Modifications ¹
- Meals: home delivered ¹ and congregate ³

- Medical Supplies²
- Mental Health Day Treatment Services (in all settings)²
- Mental Health Services, except those provided by a physician or on an inpatient basis²
- Nursing Facility (all stays including Intermediate Care Facility for People with Mental Retardation (ICF/MR) and Institution for Mental Disease (IMD))²
- Nursing Services² (including respiratory care, intermittent and private duty nursing) and Nursing Services¹
- Occupational Therapy (in all settings except for inpatient hospital)²
- Personal Care²
- Personal Emergency Response System Services¹
- Physical Therapy (in all settings except for inpatient hospital)²
- Prevocational Services¹
- Protective Payment/Guardianship Services¹
- Residential Services: Certified Residential Care Apartment Complex (RCAC)¹, Community-Based Residential Facility (CBRF)¹, Adult Family Home¹
- Respite Care (for care givers and members in non-institutional and institutional settings)¹
- Specialized Medical Supplies¹
- Speech and Language Pathology Services (in all settings except for inpatient hospital)²
- Supported Employment¹
- Supportive Home Care¹
- Transportation: Select Medicaid covered (i.e., Medicaid covered Transportation Services except Ambulance and transportation by common carrier²) and non-Medicaid covered¹

¹ The services listed in this subsection with a (1) suffix are defined in Wisconsin's CMS (Centers for Medicare & Medicaid Services) approved waivers: #0367; and #0368 under s. 46.281(1)(c) Wis. Stats., and as otherwise specified in this contract.

² The services listed in this subsection with a (2) suffix are defined under s. 49.46(2), Wis. Stats., and HFS 107 Wis. Adm. Code; as further clarified in all Wisconsin Medicaid Program Provider Handbooks and Bulletins, CMO Contract Interpretation Bulletins (CIBs) and as otherwise specified in this contract.

³ The services listed in this subsection with a (3) suffix are defined in DHFS's Human Services Reporting System (HSRS) Manual and as otherwise specified in this contract.

2. *Services in the Long-Term Care Benefit Package for Members at the Intermediate Level*

The CMO shall promptly provide or arrange for the provision of all services in the LTC benefit package, consistent with the Individual Service Plan, with the following exception: members at the intermediate level, who are not residing in a nursing

facility or ICF/MR at the time of enrollment, do not have access to long-term care (i.e., care for longer than 90 calendar days) in a nursing facility or ICF/MR. Prior to admission when possible or not later than 3 business days following admission to a nursing facility or ICF-MR a member at the intermediate level of care must have the LTC Functional Screen updated by a certified screener to determine whether changes in the member's long-term health and care needs are consistent with the comprehensive level of care. The Individual Service Plan is updated based upon review of the changes in care needs and the preferences of the member. The member must be referred to the Resource Center for reassessment of level of care within 60 calendar days following discharge from the nursing home or ICF-MR.

3. *Services in the Long-Term Care Benefit Package for Members Eligible as Grandfathers*

The CMO shall promptly arrange for the provision of all services in the LTC benefit package consistent with the Individual Service Plan. If the care needs of an individual eligible for Family Care as a grandfather increase, the CMO must request re-screening by the Resource Center to determine whether the individual meets the intermediate or comprehensive level of care. Members eligible as grandfathers have access to the full benefit package and all rights of membership in the CMO.

4. *Changes in Mandated Services*

Changes to Medicaid covered services mandated by Federal or State law, and amendments to Wisconsin's CMS approved waivers subsequent to the effective date of this contract will not alter the services in the LTC benefit package for the term of this contract, unless agreed to by mutual consent, or unless the change is necessary to continue to receive Federal funds or due to action of a court of law.

a. *Per Member Per Month Payment Adjustment*

If any change in services in the LTC benefit package occur which are mandated by Federal or State law and incorporated into this contract, DHFS shall adjust the per member per month rate accordingly.

b. *Changes by Mutual Agreement*

DHFS will give the CMO 30 calendar days notice of any such change that reflects service increases, and the CMO may elect to accept or reject the service increases for the remainder of the term of this contract. DHFS will give the CMO 60 calendar days notice of any such change that reflects service decreases, with the right of the CMO to dispute the amount of the decrease within that 60 calendar day period. The CMO has the right to accept or reject service decreases for the remainder of the term of this contract.

c. *Date of Change Implementation*

The date of implementation of the change in coverage will coincide with the effective date of the increased or decreased funding. This section does not limit DHFS's ability to modify this contract for changes made necessary by the State Budget.

d. *Notification to Members*

The CMO shall notify members within ten business days after the effective date of changes in the type of services in the LTC benefit package.

5. *Services Coordinated Through Medicaid Fee-For-Service*

For members who are Medicaid beneficiaries, the following Medicaid services remain fee-for-service:

- Alcohol and Other Drug Abuse Services provided by a physician or in an inpatient setting
- Audiology
- Chiropractic
- Crisis Intervention
- Dentistry
- Eyeglasses
- Family Planning Services
- Hearing Aids
- Hospice
- Hospital: Inpatient and Outpatient, including emergency room care (except as indicated in list of covered services beginning on page 14)
- Independent Nurse Practitioner Services
- Lab and X-Ray
- Mental Health Services provided by a physician or in an inpatient setting
- Optometry
- Pharmaceuticals
- Physician and Clinic Services (except as indicated in list of covered services beginning on page 14)
- Podiatry
- Prenatal Care Coordination
- Prosthetics
- School-Based Services
- Transportation: Ambulance and transportation by common carrier

6. *Payments for Services*

The CMO is responsible for payment of all services in the LTC benefit package provided to all members listed as ADDs or CONTINUES on either the Initial or Final Enrollment Reports (see Article VIII.F, *Disenrollment*, page 84) generated for the month of coverage.

7. *Necessity or Appropriateness of Services*

The CMO shall not deny services necessary to achieve outcomes as defined in Addendum I, *Definitions* (page 105). Disputes between the CMO and members about the necessity of services are resolved through the grievance process in Article IV.G, *CMO Grievance System* (beginning on page 37). The determinations made through the grievance resolution process will be based on whether the services meet the definition of “Services Necessary to Achieve Outcomes” in this contract.

8. *Billing Members*

The CMO, its providers and subcontractors will not bill a member for services in the LTC benefit package that received advanced authorization from the CMO and were provided during the member's enrollment period in the CMO, except as provided for in the 1915(c) waiver post-eligibility treatment of income. This provision pertains even if:

- a. The CMO becomes insolvent;
- b. DHFS does not pay the CMO;
- c. DHFS or the CMO does not pay the provider that furnishes the services under a subcontractual, referral or other arrangement; and,
- d. Payment for services furnished under a subcontract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the CMO provided the service directly.

In the event of the CMO's insolvency, the CMO shall not bill members for debts of the CMO.

The CMO, its providers and subcontractors shall not bill a member for co-payments and/or premiums for services in the LTC benefit package under this contract and provided during the member's period of CMO enrollment. This provision shall continue to be in effect if the CMO becomes insolvent. See Article II.C(3), *Enrollment While Eligibility is Pending* (page 7), for related requirements.

9. *Cost Sharing*

- a. The CMO is responsible for collection of the member's monthly cost-share. The CMO's collection of monthly cost-share from waiver eligible Family Care participants is subject to Family Care waiver policy. A waiver eligible Family Care participant is not required to pay any amount in cost share which is in excess of the average cost, as determined by DHFS, of waiver services in a given month for all CMO waiver participants in the same target group.
- b. The CMO is responsible for the ongoing monitoring of the cost share/spenddown amounts of its members and reporting changes in those amounts to the Resource Center. The CMO is responsible for knowing what the member's ongoing medical/remedial expenses are and reporting changes in those amounts to the Resource Center.
- c. Individuals who have been found to meet no Family Care financial eligibility criteria but who, after discussion with the Resource Center, elect to further explore eligibility, as a private pay person, may purchase case management from the CMO in the form of a comprehensive assessment and care plan.

- i. Following the CMO's completion of the comprehensive assessment and development of a care plan (paid for by the applicant), the CMO compares the person's actual care plan costs to the individual's maximum cost share obligation.
- ii. Should the person's actual care plan costs reveal to be greater than the individual's calculated maximum cost share obligation, the person may re-apply for Family Care as a Non-MA applicant using the determined actual care plan cost. The CMO refers the person back to the Resource Center who notifies ES of the actual care plan cost information.
- iii. If the reapplication finds that the person is eligible for Family Care, enrollment may be backdated up to 3 months to cover the cost of the comprehensive assessment and care plan. However, this date can be no earlier than the day on which the CMO first began to serve the person. If the member has already paid the CMO the fee of the comprehensive assessment and care plan, the CMO reimburses the member by discounting her/his cost share. The CMO is responsible for payment of all Family Care benefit services provided on or after the retroactive enrollment date.

10. *Private Pay Care Management*

The CMO shall provide care management to private pay individuals as follows (Refer to Addendum I for definitions of "Case Management" and "Private Pay Individual"):

a. *Case Management Available for Purchase*

A Care Management Organization shall offer case management services, at rates approved by DHFS, to private pay individuals who wish to purchase the services. A private pay individual may purchase from the CMO any types and amounts of case management. The types and amounts of case management and the cost of the services shall be specified in a written agreement signed by the authorized representative of the CMO and the individual purchasing the service or the person's authorized representative. The private pay case management agreement shall meet the following:

- i. The CMO's rates for private pay case management shall either:
 - Be no higher than the Medicaid targeted case management rates which are in effect at the time of providing the service; or,
 - Be approved by DHFS.
- ii. The CMO shall meet with the individual to achieve the following:
 - Fully review the specific aspects of care management the individual may purchase;

- Clearly explain the cost of the service, and the billing and payment arrangements, including provisions for discontinuing service for failure to pay;
 - Clarify the specific care management tasks the individual agrees to purchase, the amount (e.g., number of hours) of care management that is being purchased, and who will be providing the care management;
 - Inform private pay individuals of their rights under Federal and State law (such as the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and the Americans with Disabilities Act) and their rights to have access to their service records in accordance with applicable Federal and State laws;
 - Inform private pay individuals that they are not eligible to purchase services from CMO's contracted providers at rates the CMO has negotiated for services it purchases for enrollees;
 - Execute a written agreement containing the specific information described above. This agreement shall be signed by an authorized representative of the CMO and by the individual purchasing the service, or that person's authorized representative.
- iii. The CMO's private pay care management service shall contain the following aspects at a minimum:
- A comprehensive assessment of the person's long-term care and health care needs;
 - Development of a care plan to meet the needs identified in the comprehensive assessment, as well as the person's identified outcomes and lifestyle preferences. The care plan in no way limits the person's ability to purchase services at his or her own expense from service providers;
 - Implementation and coordination of the care plan;
 - As appropriate, either assisting the person in filing appeals and grievances with non-CMO service providers, or referring the person for advocacy services;
 - Periodic reassessment, with appropriate updates to the care plan.
- iv. Individuals purchasing private pay care management may access the CMOs appeal and grievance process only insofar as those appeals or grievances pertain to the care management provided by the CMO. Appeals or grievances against the CMO may be filed with or appealed to DHFS only insofar as those appeals or grievances pertain to the care management

provided by the CMO. Appeals or grievances about other non-CMO services, which may be coordinated by the CMO, shall be filed with the service provider and if desired, with the appropriate regulatory agency.

b. *Limitations on Purchase of Other Services*

- i. A private pay individual may not enroll in a care management organization, but, subject to pars. ii. and iii. may purchase services other than case management services, on a fee-for-service basis, from a care management organization.
- ii. An individual who meets the definition under sub. (1) (b) 1. may purchase any service that the CMO provides directly and offers to the general public, at prices normally charged to the public.
- iii. An individual who meets the definition under sub. a. 2.i. or ii. may purchase any service purchased or provided by the CMO for its members.

B. Care Management

Note: Care Management for private pay individuals is covered in subsection 10, *Private Pay Case Management* (page 19), of this Article.

1. *Member Participation*

To ensure optimum member participation in the Individual Service Plan (ISP) and Member-Centered Plan (MCP) development and updating, and that members take an active role in decision-making regarding the long-term care and health care services they need to live as independently as possible, the CMO shall provide the support requested or needed by members, their families or other representatives, when making informed health care decisions.

Members shall receive clear explanations of (1) their condition, (2) risks involved in specific member preferences, (3) information on available treatment options or alternatives courses of care, (4), the full range of residential options, including in-home care, residential care and nursing home care when applicable, (5) the benefits, drawbacks and likelihood of success of each option, and (6) the possible consequences of refusal to follow the recommended course of care.

The CMO shall inform members of specific conditions that require follow-up, and if appropriate, provide training in self-care, including factors that hinder full participation with prescribed treatments or interventions included in the ISP and the MCP.

2. *Self-Directed Supports*

The CMO shall submit a plan for self-directed supports consistent with requirements specified in proposed HFS10.44(6) to the Department which receives approval prior to the effective date of this contract. The plan shall describe how the CMO will:

- a. Inform all members of the self-directed support option and plans to phase in self directed supports for all CMO members;
- b. Provide a mechanism by which an increasing number of members may arrange for, manage and monitor the services in the LTC benefit package directly or with the assistance of another person chosen by the member until full implementation of self-directed supports on or before January 1, 2003;
- c. Monitor the member's use of a fixed budget for purchase of services from any qualified provider;
- d. Monitor the health and safety of the member;
- e. Provide assistance in management of the member's fixed budget and services at a level tailored to the member's needs and desire for the assistance; and,
- f. Assess the self-directed support component. A report of this assessment shall be submitted to the Department 90 calendar days before the expiration date of this contract.

3. *Interdisciplinary Team Composition*

The member receives case management through a designated interdisciplinary team which, at a minimum, consists of the member, a social service coordinator and a registered nurse. Upon enrollment members shall have a choice of at least two case management teams. The team utilizes appropriate additional specialized expertise for the initial comprehensive assessment, consultation, ongoing coordination efforts and other areas as needed. Except for existing employees holding a position comparable to a social service coordinator at the time of the initial contract effective date, the social service coordinator is required to have a minimum of a four-year bachelor's degree in the social services area (e.g. social work, rehabilitation psychology, etc.).

The service coordinator and nurse shall have knowledge of community alternatives for the target populations served by the CMO and the full range of long-term care resources. Additionally, the service coordinator and nurse shall have specialized knowledge of the conditions of the target populations served by the CMO.

The CMO shall ensure ease of access for members to the interdisciplinary team such as by designation of one member of the interdisciplinary team as the member's primary care manager.

4. *Individual Service Plan and Member-Centered Plan Development and Review*

CMO interdisciplinary teams are responsible for the preparation of the initial plans for members and for periodic reviews and updates of plans according to timeframes specified below to determine the appropriateness and adequacy of the services and to ensure that services furnished are consistent with the nature and severity of the member's disability. The DHFS shall review and approve a sample of CMO plans on a regular, ongoing basis. The CMO shall make all necessary documentation available

to the DHFS or its designee either on-site at the CMO or off-site and a specified location for this review. DHFS reviewers shall review available information about services, supports, time frames, staff responsible for service provision, and documentation of member preferences and needs to determine if all member needs are identified and addressed adequately, and shall approve those plans that address all of the member's needs. If the reviewer finds that services in a plan do not agree with the member's disabilities and needs in critical areas, or if basic member needs are overlooked in the assessment, a same-day referral shall be made to the DHFS and the CMO. If after further investigation, it is determined that the effect on the member is serious, the CMO shall take corrective action within specified time frames to ensure that the essential needs of the member are adequately addressed. In this circumstance, the plan will be pended for approval until identified problems are corrected. The DHFS shall track and trend review findings and provide a periodic report to the CMO. If a CMO is found to have an unfavorable trend towards pended approval of plans, the rate of review may be intensified.

5. *Initial Individual Service Plan (ISP)*

The CMO is responsible for providing needed services beginning on the date of enrollment. Upon enrollment, the interdisciplinary team shall develop and implement an initial ISP, based on information received from the Resource Center and on the CMO's initial assessment of the member's needs. The initial ISP shall be developed by the CMO in conjunction with the member. The CMO shall contact the member within three calendar days of enrollment to identify initial care needs and the initial ISP shall be signed by the member within ten days of enrollment.

6. *Initial Comprehensive Assessment*

a. *Procedure*

The member is central to the assessment process. The CMO shall use an assessment protocol that includes a face-to-face interview with the member and that comprehensively assesses and identifies the member's needs and strengths, preferences, informal supports, and long-term care outcomes and identifies any ongoing conditions of the member that require a course of treatment or regular care monitoring. The interdisciplinary team shall encourage the active involvement of any informal supports in the assessment as desired by the member. The interdisciplinary team, member and informal supports shall jointly participate in completing a comprehensive assessment within 30 calendar days of the enrollment date. If the CMO has been providing services to an individual while that individual's eligibility is pending, the comprehensive assessment shall be completed within 30 calendar days of the date eligibility is established. If the CMO is unable to assess the member within this timeframe, the CMO must ensure that the reason why the member could not be assessed is documented in the member's record.

b. *Documentation*

The CMO shall use a standard format developed or approved by the DHFS for documenting the information collected during the Comprehensive Assessment. The CMO shall, document enough information in each area assessed to be able to document the member's needs and ongoing conditions of the member that require a course of treatment or regular care monitoring and strengths. Information about the member's values, preferences and desired outcomes shall be recorded on the ISP/MCP document. The assessment format shall consist of at least the following:

- i. Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs);
- ii. Physical Health and Nutrition;
- iii. Safety;
- iv. Member Rights and Responsibilities, Autonomy and Self-Determination, including person's understanding of his/her rights, whether person has guardian or power of attorney for health care, preferences for executing advance directives, desire to self-manage care plan, determination of least restrictive setting if appropriate, personal preferences in regard to services, caregivers, and daily routine;
- v. Personal values, including results of a life review or Futures Planning;
- vi. Communication;
- vii. Mental health and cognition including Alcohol and Other Drug Abuse (AODA) issues;
- viii. Presence of informal supports;
- ix. Social interaction and community integration;
- x. Preferred living situation including identification of a member's preference for a private room for a person considering alternative residential services;
- xi. Education and vocational activities; and,
- xii. Economic Resources.

c. *Purpose*

The purpose of the comprehensive assessment report together with the Individual Service Plan (ISP) and Member-Centered Plan (MCP) is to provide a unique description of the individual to assist the interdisciplinary team, the member and any service provider or other authorized party to have a clear understanding of the needs, strengths and desires of the individual. The successful comprehensive

assessment, MCP and ISP will provide information to allow any provider or authorized person to clearly identify the individual and the services and supports necessary to meet all individual needs and preferences and come to a common understanding of the approach the team is using to coordinate the member's care and services. The criteria the Department will use to evaluate the comprehensive assessment, MCP and the ISP are timeliness, comprehensiveness, and relevancy to the member.

7. *Initial Comprehensive Assessment Appeals and Grievances*

When the initial comprehensive assessment results in the member disagreeing with any of the assessment findings, the CMO shall discuss the issue with the member, and follow procedures outlined in Article IV.G, *CMO Grievance System* (page 37).

8. *Individual Service Plan and Member-Centered Plan Development*

The interdisciplinary team shall encourage the active involvement of the member's informal supports in the development of the Individual Service Plan (ISP) and Member-Centered Plan (MCP). The interdisciplinary team, member and any informal supports shall jointly participate in the development of the ISP and MCP based on the comprehensive assessment within 60 calendar days of the enrollment date. If the CMO has been providing services to an individual while that individual's eligibility is pending, the MCP and ISP shall be completed within 60 calendar days of the date eligibility is established.

For members with cognitive disabilities, the CMO shall ensure that family members, friends and other informal supports who know the member assist in conveying the member's preferences in the development of the MCP and ISP. In the development of the MCP and ISP, the CMO shall provide assistance as requested or needed to members in exercising their choices about where to live, with whom to live, work, daily routine, and services.

a. *Individual Service Plan*

The ISP is a document that lists services and supports provided or arranged by the CMO to address all needs identified in the functional screen and comprehensive assessment and all services and supports provided that are consistent with the nature and severity of the member's identified needs. The ISP shall contain at a minimum, the type of service or support to be furnished, the amount, the frequency and duration of each service (i.e., start and stop date), and the type of provider to furnish each service. It is a supplement to the Member-Centered Plan document described below.

b. *Member-Centered Plan*

i. *Purpose*

Member-centered planning is an ongoing process that establishes how the member's identified strengths, skills and resources, informal, community and resources available through the Family Care benefit, will be used to achieve member defined outcomes. The member-centered planning process shall be documented in a single, comprehensive record of how LTC service

and support needs and acute and primary service needs are coordinated including how the plan is coordinated with community services and natural support systems that exist outside the CMO. The Member-Centered Plan (MCP) shall also specify the member's desired outcomes, steps/supports needed to achieve the outcome and the person(s) on the team responsible for tracking of steps/supports related to achieving outcomes identified on the plan. The criteria the Department will use to assess the effectiveness of Member-Centered Plans are: timeliness of the assessment and planning; continuity of assessment and planning; and, member-centered approach to assessment and planning, which means that the outcomes identified in the plan are member-centered and member-directed.

ii. *Procedure and Documentation Requirements*

The CMO interdisciplinary team shall be responsible for assuring that the MCP is developed and implemented in accordance with the following processes:

- The MCP shall be developed after interaction between the member, the members of the interdisciplinary team, and support persons identified by the member;
- The CMO shall use a standard format for documenting the information collected during the member-centered planning process. The Member-Centered Plan shall consist of at least the following:
 - Expected outcomes;
 - Member's goals and preferences;
 - Needs and preferences identified in the comprehensive assessment;
 - Type of residential setting;
 - Services or interventions to be provided, in order to meet the identified needs and honor the preferences identified in the comprehensive assessment;
 - Coordination of services outside the LTC benefit package;
 - The specific period of time covered by the MCP; and,
 - Party responsible for providing each service (including informal supports).

iii. *Documentation*

The CMO is responsible for furnishing services in the LTC benefit package based on the ISP/MCP, and coordinating all other services provided to the member from the date of enrollment. The ISP/MCP shall address comprehensive service needs regardless of whether the service is covered in the LTC benefit package or there is another source of payment (e.g., Medicare, Medicaid fee-for-service, private insurance).

In addition to informal supports, the interdisciplinary team shall actively involve providers, agencies and others identified in the ISP/MCP in

developing and revising the ISP/MCP. Involvement of participants shall be based on the preference of the member, and the parties' ability to contribute to the ISP/MCP regardless of provider type (e.g. primary care physician, psychiatrist).

The ISP/MCP shall be reviewed with and signed by the member, or the member's authorized representative as appropriate, to indicate his/her agreement with the ISP/MCP. The CMO shall provide the member with a copy of the signed ISP/MCP.

The CMO shall document in the member record instances when the ISP/MCP differs from the member's preference, (e.g. the CMO substitutes a preferred service or support arrangement with another of comparable quality and efficacy) and the reason for not meeting the member's preference, and whether or not the member agrees with the substitution.

The CMO shall document in the member record instances when the member refuses a specific service or services. However, when a member refuses a service, the CMO must have a process for assuring that the member has been made aware of the risks, if any, that are associated with refusing a service(s), to the extent possible.

9. *Providing, Arranging and Coordinating Services*

- a. The interdisciplinary team is formally designated as being primarily responsible for coordinating the member's overall long-term care and health care. In accordance with the ISP/MCP, the interdisciplinary team shall authorize, provide, arrange for or coordinate services in the LTC benefit package, and coordinate all other services identified in the ISP/MCP, in a timely manner.

In addition to any standards set by the CMO, the CMO must meet and require its providers to:

- i. Meet State and CMS (Centers for Medicare & Medicaid Services) waiver standards for timely access to care and member services, taking into account the urgency of need for services.
 - ii. Establish mechanisms to ensure compliance with State and CMS waiver standards.
 - iii. Monitor continuously to determine compliance with State and CMS quality standards; and take corrective action if there is failure to comply.
- b. The coordination of services includes ensuring that the informal support services are involved appropriately and in accordance with the member's preferences. The CMO shall ensure coordination of services internally and with services available from community organizations and other social programs.

- c. The CMO will arrange for services not covered in the benefit package, and instruct members on how to obtain these services including identification of transportation services and how they are provided by the CMO. The CMO shall at a minimum:
 - i. Within 30 calendar days of enrollment, document the member's primary care provider, specialty care provider(s), and psychiatrist (if applicable);
 - ii. Contact member's primary care provider and specialty care providers(s) to provide information about services not covered in the benefit package and possible alternative payment sources including Medical Assistance available to the member;
 - iii. Provide information about the CMO's procedures for accessing services in the LTC benefit package;
 - iv. Obtain the member's informed consent to receive and share appropriate health care information between and among all service providers;
 - v. Provide member education in the effective use of primary care, specialty care and emergency services;
 - Any procedures the provider must follow to contact the CMO before the provision of urgent or routine care;
 - Procedure for creating and coordinating follow-up treatment plan;
 - Policy for sharing of information and records between the CMO and emergency service provider;
 - Process for arranging for appropriate hospital admissions;
 - Policies regarding other continuity of care issues;
 - Agreements, if any, between the CMO and the provider regarding indemnification, hold harmless, or any other deviation from malpractice or other legal liability which would attach to the CMO or emergency services provider in the absence of such an agreement.

10. *Individual Service and Member-Centered Plan Updates*

The member and interdisciplinary team shall review and update the ISP/MCP periodically as the member's preferences, situation and condition changes, but not less than every 180 calendar days, or the ISP/MCP fails to accomplish the planned outcomes.

When the ISP/MCP update results in a termination, suspension, or reduction of a service covered under the Family Care benefit (including services authorized by a managed care organization the member was previously enrolled in or through Medicaid fee-for-service), the CMO shall discuss with the member the specific change in service and the reason(s) supporting the change in service, and follow procedures outlined in Article IV.G(3), *Notice of Action* (page 39).

11. *Individual Service Plan and Member-Centered Plan Appeals and Grievances*

When the ISP/MCP development or update results in denying, reducing, delaying or terminating a current service (including services authorized by a managed care organization the member was previously enrolled in or through Medicaid fee-for-service), the CMO shall discuss with the member the specific denial or change in service, and the reasons supporting the denial or change in service, and follow procedures outlined in Article IV.G, *CMO Grievance System* (page 37).

12. *Future Re-Assessments*

After the initial comprehensive assessment described above, the CMO conducts re-assessments based on:

- a. Previous LTC Functional Screens and assessments;
- b. Changes in the member's long-term care and health care condition and situation; or,
- c. Requests for an assessment by the member, the member's representative, the member's primary medical provider, or an agency involved with the member.

13. *Interdisciplinary Team and Member Contacts*

The members of the interdisciplinary team shall have sufficient contact and interaction with members to develop and maintain a relationship, be responsive to changing member needs and preferences, and monitor the appropriateness and quality of services. These contacts shall be recorded in the member record.

14. *Transition of Care*

Within 10 business days of a member's request the CMO shall provide a clinical determination regarding the necessity of a member to continue receiving services from a non-CMO mental health or AODA provider. If the CMO determines that the member does not need to continue with the non-CMO provider, it shall ensure a successful transition to a CMO provider.

15. *Member Record*

Develop and maintain a record on each member as further discussed in Article VII.B, *Member Records* (page 74).

C. 24 Hour Coverage

The CMO shall be responsible 24 hours each day, seven days a week for providing members with access to services in the LTC benefit package; coordination of services that remain Medicaid fee-for-service (for members who are Medicaid beneficiaries); and linkages to Adult Protective Services. The CMO shall:

1. Have one phone number members or individuals acting on behalf of members can call at any time to obtain advance authorization for services in the LTC benefit package. This number must provide access to individuals with authority to authorize the services in the LTC benefit package as appropriate. Individuals at this number must also have familiarity with the CMO and the CMO's provider network.
2. Respond to such calls within 30 minutes.
3. Be able to communicate with the caller in the language spoken by the caller.
4. Log these calls with time, date and any pertinent information related to person(s) involved, resolution and follow-up instructions.
5. Notify members and DHFS of any changes of this one phone number within seven business days of change.

D. Member Safety and Risk

The CMO shall assure member health, safety and well being and implement a policy that expressly prohibits all forms of abuse, neglect, exploitation and mistreatment of members by CMO employees and providers. This policy shall include instruction in the proper reporting procedures when abuse or neglect is suspected.

1. Critical Incidents

- a. The CMO shall gather and report specific information related to a critical incident locally to its Governing Board, internal committees, and the Local Long-Term Care Council, and maintain client specific information in the member record. (See Article VII.B(10),
- b. *Contents of Member Records*, page 75.)
- c. The CMO shall report critical incident aggregate data to DHFS as part of the quarterly narrative report consistent with the Critical Incidents protocol (see Appendix VIII, *Critical Incidents Protocol*, page 135.)
- d. The CMO shall report all unexpected and accidental deaths, and any death potentially due to abuse or neglect to DHFS as soon as possible after the death, but within forty-eight (48) hours of when the CMO learns of the death and shall cooperate with DHFS in the investigation of any unexpected or accidental death. An unexpected death is any death that by statute or regulation must be reported to the coroner or medical examiner, or that is reported to the Department of

Regulation and Licensing or any part of the Department of Health and Family Services, or that is the result of trauma, or of which the circumstances are suspicious, obscure, or otherwise unexplained, or any death where a grievance, appeal or fair hearing is pending at the time of death. (see Article VII.B, *Member Records*, page 74)

2. *Individual Choices in Safety and Risk*

- a. The CMO shall develop specific written policies that address decision-making about care as it relates to members' safety and risk. These policies shall establish standards and methods for determining acceptable risk for members, including members with a cognitive impairment or mental illness. The policies must include a member's right to freedom from unnecessary physical or chemical restraint, and specify mechanisms to balance member needs for safety, protection, good physical health and freedom from accidents, with over-all quality of life and individual choice and freedom. CMO staff and other appropriate individuals shall be informed of these policies on an ongoing basis.

The CMO shall have a mechanism to monitor, evaluate and improve its performance in the area of safety and risk issues. These mechanisms shall ensure there are individualized supports in place to facilitate a safe environment for each member. The CMO shall assure its performance is consistent with the understanding of the desired member outcomes and preferences. The CMO shall include family members and other informal supports when addressing safety concerns per the member's preference.

E. **Prevention and Wellness**

1. *Prevention and Wellness Plan*

Prevention and wellness shall be part of the normal course of communications with members, and the development of the member's Individual Service Plan (ISP) and Member-Centered Plan (MCP). The CMO shall inform all members of contributions which they can make to the maintenance of their own health and the proper use of long-term care and health care services. The activities and materials used in the prevention and wellness activities shall be accessible by DHFS and the Centers for Medicare & Medicaid Services (CMS). The CMO's plan for implementing the prevention and wellness program must be submitted to DHFS and approved prior to the first Health and Community Supports contract between the CMO and DHFS. Upon contract renewal and at any time DHFS determines there has been a significant change in the CMO's capacity to offer prevention and wellness services or in the CMO's projected membership, it may require the CMO to submit documentation to demonstrate its capacity to provide prevention and wellness services.

2. *The Prevention and Wellness Program*

The CMO's prevention and wellness program shall include the following components:

a. *Program Coordination*

Designated staff are responsible for the coordination and delivery of services in the program.

b. *Practice Guidelines*

Practice guidelines are guidelines that are developed to assist health care professionals to apply the current best evidence in making decisions about the care of individual members. The CMO shall use practice guidelines for prevention and wellness services that include member education, motivation and counseling about long-term care and health care related services. The CMO must disseminate guidelines to providers who are expected to use the guidelines and, upon request, to members.

Practice guidelines that are condition-specific and/or disease related shall include the following elements:

- i. Overview of condition/disease;
- ii. Information related to anticipating, recognizing and responding to condition/disease related symptoms;
- iii. Information related to best practice standards for prevention and management of condition/disease;
- iv. Guidelines/process for interdisciplinary team to use regarding negotiating incorporation of condition/disease prevention and management plan with member into the MCP and ISP;
- v. Plan for quality assurance monitoring of guideline effectiveness.

c. *Measurement*

The capacity to collect, analyze and report data necessary to measure the performance of the prevention and wellness program. The reports based on this data shall be communicated to providers and members.

d. *Program Resources*

Mechanisms for facilitating appropriate use of prevention and wellness services and educating members on health promotion.

e. *Disease Prevention*

Information and policies on prevention of abuse and neglect, and the prevention and management of diseases which affect the populations served by the CMO. This includes specific information for persons who have or who are at risk of developing health problems that are likely to benefit from preventive practices. Hypertension and diabetes are examples of such health problems.

f. *Independent Functioning*

Information and policies on maintaining and improving members' functional status, and the ability to perform ADLs and IADLs more independently, for the populations served by the CMO. This includes specific information for persons who have or who are at risk of impaired ability to function independently and are likely to benefit from preventive practices.

g. *Outreach Strategies*

Outreach strategies for identifying and reaching members who are least likely to receive adequate preventive services.

h. *Special Health Issues*

The dissemination of information relevant to the membership, such as nutrition, AODA prevention, reducing self mutilation behaviors, exercise, skin integrity, self care training, and coping with dementia.

i. *General Information*

The dissemination of information on how to obtain the services of the prevention and wellness program (e.g. Resource Center, public health department etc.), as well as additional information on, and promotion of, other available prevention services offered outside of the CMO, such as special programs on women's health.

j. *Sensitivity to Population*

Long-term care and health care related educational materials produced by the CMO shall be appropriate for its target population(s) and reflect sensitivity to the diverse cultures served. An internal advisory body composed of people meeting the functional eligibility requirements of the CMO, experts on long-term care and health related subjects will establish a process to review and approve the health educational materials produced by the CMO. Also, if the CMO uses material produced by other entities, the CMO shall review these materials for appropriateness to its target population(s) and for sensitivity to the diverse cultures served. Finally, the CMO shall make all reasonable efforts to locate and use culturally appropriate long-term care and health care-related materials.

F. Provision of Interpreters

The CMO shall provide interpreter services for members as necessary to ensure availability of effective communication regarding treatment, medical history, health education and information provided to members. Interpreter services are to accommodate foreign languages and impairments (e.g. sign language) of members. (For related information, refer to Article VII.C, *Accessibility of Language*, page 76). Furthermore, the CMO shall:

1. *Availability*

Provide for 24 hours a day, seven days a week access to interpreters conversant in languages spoken by members in the CMO. Also, upon a member or provider request for interpreter services in a specific situation where care is needed for a service in the LTC benefit package, the CMO shall make all reasonable efforts to provide an interpreter in time to assist adequately with the necessary care.

2. *Use of Professional Interpreters*

Use professional interpreters when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend as interpreter is inappropriate.

3. *Civil Rights of 1964*

Provision of interpreter services must be in compliance with Title VI of the Civil Rights Act of 1964.

G. Adult Protective Services

1. *Access to Adult Protective Services*

For members in need of Adult Protective Services (APS), the CMO shall involve the entity or Department (which the County has arranged to administer APS) in the following capacities:

- a. The CMO shall invite an APS staff person to participate in the Individual Service Plan (ISP), ISP updates, comprehensive assessment and re-assessments; and,
- b. The CMO shall invite an APS staff person to participate on the interdisciplinary team to the extent that the APS staff person makes recommendations as necessary to fulfill their APS responsibilities.

2. *Protective Services Administration*

If the County has made arrangements for the CMO to administer APS, the CMO shall assure that CMO staff with expertise in APS participate on the interdisciplinary team in the capacities noted above for those members in need of APS.

3. *Court Ordered Services*

The CMO shall provide for court ordered treatment if it is a service in the LTC benefit package for which the CMO would be the primary payer and the member has been court ordered into placement or services through Chapter 51 or 55 of the Wis. Stats.

H. Advance Directives

The CMO shall comply with requirements of federal and state law with respect to advance directives (e.g., living wills, durable power of attorney for health care) and shall maintain written policies and procedures related to advance directives. The CMO shall:

1. *Written Information*

Provide written information at time of CMO enrollment to all adults receiving medical care through the CMO regarding:

a. *Members' Rights*

The individual's rights under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and

b. *Policies*

The CMO's written policies respecting the implementation of such rights.

2. *Documentation*

Document in the member record whether or not the member has executed an advance directive.

3. *Fair Treatment*

The CMO shall not base the provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive. This provision shall not be construed as requiring the provision of care which conflicts with an advance directive.

4. *Education*

Provide education for staff and the community on issues concerning advance directives.

5. *Referral*

Provide referral to appropriate community resources, including the resource center, for any member or individual seeking assistance in the preparation of advance directives.

The above provisions shall not be construed to prohibit the application of any Wisconsin law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider who, as a matter of conscience, cannot implement an advance directive.

IV. Protection of Member Rights

A. Member rights

Members have the right to all of the following:

1. Freedom from unlawful discrimination in applying for or receiving the Family Care benefit.
2. Accuracy and confidentiality of member information.

3. Prompt eligibility, entitlement and cost-sharing decisions and assistance.
4. Access to personal, program and service system information.
5. Choice to enroll in a CMO, if eligible, and to disenroll at any time.
6. Information about and access to all services of resource centers and CMOs within standards established under this chapter to the extent that the member is eligible for such services.
7. Support for all members in understanding their rights and responsibilities related to Family Care, including due process procedures, and in providing their comments about resource centers, CMOs and services, including through appeals, grievances and requests for department review and fair hearings. Resource centers, CMOs and county agencies under contract with the Department shall assist members to identify all rights to which they are entitled and, if multiple grievance, review or fair hearing mechanisms are available, which mechanism will best meet member needs.
8. Support from the CMO in all of the following:
 - a. Self-identifying long-term care needs and appropriate Family Care outcomes.
 - b. Securing information regarding all services and supports potentially available to the enrollee through the Family Care benefit.
 - c. Actively participating in planning individualized services and making reasonable service and provider choices for achieving identified outcomes.
9. Receiving services identified in the individualized service plan.
10. Rights and available grievance and appeal processes beyond those specified in this chapter. For example, clients receiving treatment for mental illness may have rights under ch. 51, Stats., and review and appeal mechanisms beyond those specified in this chapter. Similarly, a client who resides in a nursing home has rights under ch. 50, Stats., and 42 CFR 483.10.

B. Member Rights and Responsibilities Education

The CMO shall provide education to members on the grievance and appeal process within 60 days of enrollment. At a minimum, this education process shall include reviewing the CMO grievance and appeal process described in the member handbook. The CMO shall work proactively with the membership to encourage the use of the internal appeal and grievance process as the first step in the resolution of issues.

C. Member Rights Specialist

The CMO shall provide a member rights specialist. The member rights specialist shall provide support for all members in understanding their rights and responsibilities related to Family Care, including due process procedures, and in providing their comments about resource centers, CMOs and services, including through grievances, appeals and requests for department review and fair hearings. The member rights specialist shall assist members to identify all rights to which they are entitled and, if multiple grievance, review or fair hearing mechanisms are available, which mechanism will best meet member needs.

D. CMO Advocacy Services

The CMO shall designate a CMO employee to serve as a member advocate within the agency. The CMO member advocate shall report directly to top level management of the CMO, and shall perform the following functions at a minimum:

1. Follow-up with new enrollees within two months after enrollment to answer questions and make certain members are aware of the advocacy services available to them;
2. Assist individual members with issues and concerns that relate to the care management or the services provided through the CMO; and,
3. Assist in assuring quality services throughout the CMO.

E. Authorized Representatives

The CMO shall include the member's authorized representative (e.g. guardian, power of attorney for health care) in communications between the CMO and the member (e.g. member rights and responsibilities, development of Individual Service Plan), and in providing documents to the member (e.g. member handbook). The CMO shall allow the member's authorized representative to facilitate care or treatment decisions when the member is unable to do so.

F. Informal Resolution

Members shall obtain a prompt resolution, through established procedures, of issues raised by the member, including appeals and grievances. Members shall have the option to be represented by an advocate, peer or representative in these processes. Whenever possible the CMO shall attempt to resolve appeals and grievances informally. Attempts to resolve informally, however, do not relieve the CMO of any responsibility to comply with all requirements of the grievance process including timely resolution and prompt notice of any decisions.

G. CMO Grievance System

1. Definitions

As used in this Article (Article IV, *Protection of Member Rights*, page 35) the following terms have the indicated meanings:

a. *Action* means:

- i. The denial or limited authorization of a requested service, including the type or level of service;
- ii. The reduction, suspension, or termination of a previously authorized service;
- iii. The denial, in whole or in part, of payment for a service;
- iv. The failure to provide services and support items included in the member's MCP/ISP in a timely manner, as defined by the State;
- v. The failure of a CMO to act within the timeframes of this Article for resolution of grievances or appeals; or
- vi. The development of an individualized service plan that is unacceptable to the member because any of the following apply:
 - The plan is contrary to an enrollee's wishes insofar as it requires the enrollee to live in a place that is unacceptable to the enrollee.
 - The plan does not provide sufficient care, treatment or support to meet the enrollee's needs and identified Family Care outcomes.
 - The plan requires the enrollee to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the enrollee.

b. *Appeal* means a request for review of an action, as "action" is defined in this section.

c. *Grievance* means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the CMO level and the DHFS level, and access to the State fair hearing process. (Subjects for grievances include any act, decision or omission by the CMO, including but not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

2. *Grievance and Appeal system*

- a. The CMO must have a system in place for members that includes a grievance process, an appeal process, and access to the State's fair hearing system.

b. Filing Requirements:

i. Authority to file.

- A member may file a grievance and a CMO level appeal and a request for DHFS review and may request a State fair hearing.
- A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file a CMO appeal.

ii. Timing. The member shall file the grievance, appeal or request for fair hearing within 45 days from the date on the CMO's notice of action. Within that timeframe, any of these filings may be made separately or concurrently

iii. Procedures.

- The member may file a grievance either orally or in writing either with the State or with the CMO.
- The member or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.
- The member may file a request for fair hearing in writing with the Division of Hearing and Appeals in the Department of Administration.

3. *Notice of Action*

a. Language and format. The notice must be in writing and must meet the language and format requirements of this contract for communications to members to assure ease of understanding.

b. Content of notice. The notice must explain the following:

- i. The action the CMO or its contractor has taken or intends to take.
- ii. The reasons for the action.
- iii. The member's or the provider's right to file a CMO appeal.
- iv. The member's right to request DHFS review.
- v. The member's right to request a State fair hearing.
- vi. The procedures for exercising the rights specified in this paragraph.

- vii. The member's right to appear in person before the CMO personnel assigned to resolve appeals and grievances
 - viii. The circumstances under which expedited resolution is available and the procedure to request it.
 - ix. The availability of independent advocacy services and other local organizations that might assist the member in a grievance, appeal, DHFS review or fair hearing.
 - x. That the member may obtain, free of charge, copies of member records relevant to the grievance, appeal, DHFS review or fair hearing and how to obtain copies.
 - xi. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.
- c. Timing of notice. The CMO must mail the notice within the following timeframes:
- i. For termination, suspension, or reduction of previously authorized services, at least 10 days prior to the date of the action.
 - ii. For denial of payment, at the time of any action affecting the claim.
 - iii. For standard service authorization decisions that deny or limit services, within the timeframe specified in Article VI.E(3), *Process Direct Requests that are Determined to be not Necessary or Appropriate* (page 70) .
 - iv. If the CMO extends the timeframe in accordance with Article VI.E, *Authorization of Services and Utilization Management* (page 68) it must:
 - Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and,
 - Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
 - v. For service authorization decisions not reached within the timeframes specified for service authorizations (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.
 - vi. For expedited service authorization decisions, within the timeframes specified in Article VI.E(6), *Timeframe for Expedited Authorization Decisions* (page 71) of this contract.

4. *CMO Handling of Grievances and Appeals*

- a. General requirements. In handling grievances and appeals, the CMO must meet the following requirements:
 - i. Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
 - ii. Allow members to involve anyone (e.g. significant other, professional advocate) in the grievance and appeal process.
 - iii. Acknowledge receipt of each grievance and appeal in writing within five days.
 - iv. Ensure that the individuals who make decisions on grievances and appeals are individuals:
 - Who were not involved in any previous level of review or decision-making; and,
 - Include at least one member or one person who meets the functional eligibility for one of the target populations served by the CMO. This person must be free from conflict of interest regarding his or her participation in the governing board/committee.
 - Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.
 - An appeal of a denial that is based on lack of medical necessity.
 - A grievance regarding denial of expedited resolution of an appeal.
 - A grievance or appeal that involves clinical issues.
- b. Special requirements for appeals. The process for appeals must:
 - i. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.
 - ii. Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The CMO must inform the enrollee of the limited time available for this in the case of expedited resolution.)

- iii. Provide the member and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.
- iv. Include, as parties to the appeal:
 - The member and his or her representative; or,
 - The legal representative of a deceased member's estate
- c. The governing board of the CMO shall review and resolve appeals and grievances. This function may be delegated in writing to a grievance committee.

5. *CMO Standard Appeals and Grievance Resolution*

- a. Basic rule. The CMO must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within timeframes specified in this section.
- b. Specific timeframes:
 - i. Standard disposition of grievances. For standard disposition of a grievance and notice to the affected parties, the timeframe is as expeditiously as the member's situation and health condition requires, but no later than 20 business days after the CMO receives the grievance.
 - ii. Standard resolution of appeals. For standard resolution of an appeal and notice to the affected parties, as expeditiously as the member's situation and health condition requires, but no later than 20 business days after the CMO receives the appeal. This timeframe may be extended under paragraph (c) of this section.
 - iii. Expedited resolution of appeals. For expedited resolution of an appeal and notice to affected parties, not later than 3 working days after the CMO receives the appeal. This timeframe may be extended under paragraph (c) of this section.
- c. Extension of timeframes:
 - i. The CMO may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if:

- The enrollee requests the extension; or,
 - The CMO shows to the satisfaction of the DHFS, that there is need for additional information and how the delay is in the enrollee's interest.
- ii. Requirements following extension. If the CMO extends the timeframes, it must--for any extension not requested by the member, give the member written notice of the reason for the delay.
- d. Format of notice.
 - i. For all grievances and appeals, the CMO must provide written notice of disposition.
 - ii. For notice of an expedited resolution, the CMO must also make reasonable efforts to provide oral notice.
 - e. Content of notice of resolution. The written notice of the resolution must include the following:
 - i. The results of the resolution process and the date it was completed.
 - ii. For appeals and grievances not resolved wholly in favor of the members:
 - The right to request a DHFS review or State fair hearing, and how to do so;
 - The right to request to receive benefits while the review or hearing is pending, and how to make the request; and,
 - That the member may be held liable for the cost of those benefits if the review or hearing decision upholds the CMO's action.

6. *CMO Expedited Resolution of Appeals*

- a. General rule. The CMO must establish and maintain an expedited review process for appeals, when the CMO determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
- b. Punitive action. The CMO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a member's appeal.

- c. Action following denial of a request for expedited resolution. If the CMO denies a request for expedited resolution of an appeal, it must:
 - i. Transfer the appeal to the timeframe for standard resolution in accordance with subsection 5, above;
 - ii. Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two calendar days with a written notice.

H. Department Appeal and Grievance Resolution Process

1. General Review Process

The department shall complete a timely review, investigation and analysis of the facts surrounding member appeals or grievances in an attempt to resolve concerns and problems informally, whenever either of the following occurs:

- a. A member makes an appeal or grievance directly to the department.
- b. A member requests department review of a decision arrived at through a county agency, resource center or care management organization grievance process.

2. Timeliness of Review

The department shall complete its review under sub. 1 above within 20 days of receiving a request for review from a member, unless the member and the department agree to an extension for a specified period of time.

3. Concurrent Review Process

Whenever the department receives notice from the department of administration's division of hearings and appeals that it has received a fair hearing request, the department shall use the process in sub. 1 above to conduct a concurrent review in accordance with s. HFS 10.55 (4).

I. Fair Hearing Process

1. Request for Fair Hearing

A member can file a request for a fair hearing process for the following types of incidences before, during or after using the CMO grievance process:

- a. Failure to provide timely services and items that are included in the individual service plan;
- b. Reduction of services or items in the LTC benefit package;
- c. The Individual Service Plan (ISP) is unacceptable to the member because the ISP requires the member to live in place that is unacceptable to the member;

- d. The services or items identified in the ISP are insufficient to meet the member's needs, or are unnecessarily restrictive or unwanted by the member; or,
 - e. Involuntary disenrollment.
- 2. *When to File*

The member must file the request for a fair hearing within 45 days of one the types of incidences noted above, or receipt of written notice from the CMO or DHFS (whichever is later).
- 3. *Timelines*

A decision will be made through the fair hearing process as expeditiously as the member's situation or health condition requires. Any formal decision made through the fair hearing process under this section, shall be subject to member grievance rights as provided by State and Federal laws and rules. The fair hearing process will include receiving input from the member and the CMO in considering the grievance.
- 4. *Access to Services*

If the CMO's grievance or appeal resolution decision to deny a service is reversed through the fair hearing process, the CMO shall authorize or provide the service as expeditiously as the member's situation or health condition requires, but no later than 30 days after the receipt of the reversal.

J. Continuation of Benefits

- 1. *When Services will Continue*

The CMO shall continue the member's current benefits until the issuance of a grievance decision under the following circumstances:

 - a. The member files a grievance by the date of the intended action, or within 14 days of receipt of the written notice from the CMO and/or DHFS (whichever is later); and
 - b. The current level of services was authorized by the CMO interdisciplinary team; and
 - c. The member requests the continuation.
- 2. *Reasonable Alternatives*

If the requested services were not authorized by the CMO interdisciplinary team, the CMO shall provide reasonable alternatives to the requested services, as appropriate, until the issuance of the grievance decision.

K. Effectuation of Grievance and Appeal Resolutions

1. *Services not furnished while the appeal is pending.*
If the CMO, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CMO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than the earlier of:
 - a. The date indicated for effectuation by the fair hearing officer or,
 - b. 30 days from the receipt of the decision.
2. *Services furnished while the appeal is pending.*
If the CMO, or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO or the CMO must pay for those services.

L. Documentation and Reporting

1. *Notice of Decision to DHFS*
If the CMO makes a decision on an appeal or grievance that is entirely or partially adverse to the member, the CMO shall submit the decision and all supporting documentation to DHFS as expeditiously as the member's situation and health condition requires, but no later than 20 days after the member receives notification of the decision from the standard grievance resolution process.
2. *CMO Records Retention*
The CMO shall retain the documents related to each appeal and grievance for three years in a central location and make them accessible to DHFS. If any action involving the documents or log is started before the expiration of the three year period (e.g. litigation, audit), the CMO shall retain the records until completion of the action and resolution of issues which arise from it or until the end of the regular three year period (whichever is later).
3. *Annual Reports*
Annually the CMO shall submit to DHFS an appeal and grievance report consisting of a summary and a log, as follows:
 - a. *Summary*
The summary shall be an analysis of the trends the CMO has experienced regarding types of issues appealed and grieved about, and regarding specific providers that are the subject of appeals or grievances. If the summary reveals undesirable trends, the CMO shall conduct an in-depth review, report the results to DHFS, and take appropriate corrective action.

b. *Log*

The log shall include the following information about each appeal and grievance:

- i. Whether it is an appeal or a grievance;
- ii. The nature of the appeal or grievance;
- iii. The timeline in which it was resolved;
- iv. The decision;
- v. Whether the appeal or grievance was resolved to the satisfaction of the member; and,
- vi. Whether a disenrollment occurred during the course of the appeal or grievance, and if so, the reason for the disenrollment.

The documentation and reporting required in this Article regarding appeals and grievances provide the basis for monitoring by the CMO and DHFS. DHFS shall review the information as part of the State quality strategy.

4. *Treatment of Records*

The requirements of this section shall be in compliance with Article V.B, and Article XIII, *Confidentiality of Records* (page 101).

M. Information to Providers

At the time of subcontracting, the CMO shall furnish providers with information regarding the grievance process as specified in Article

V. CMO Functions: Service Providers

A. Choice of Providers and Interdisciplinary Teams

1. *Information to Members*

The CMO shall inform members about the full range of provider choice available to them, including free choice of medical and other providers that remain fee-for-service.

2. *Member Choice of Providers*

For services in the LTC benefit package that involve providing intimate personal needs or when a provider frequently comes into the member's home, the CMO shall, upon request of the member, purchase services from any qualified provider who will accept and meet the provisions of the CMO's subcontract for subcontractors of the same service. These services include, but are not limited to, personal care, home health, private duty nursing, supportive home care and chore service. The provisions of subcontracts for services mentioned in this paragraph shall focus on quality and

cost effectiveness, and not be constructed in such a way so as to limit the network of providers.

Delivery network. The State must ensure, through its contracts, that each CMO consistent with the scope of the CMO's contracted services, provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.

3. *Non-CMO Providers*

The CMO shall maintain a process to consider a member's request for a non-CMO provider, which is a provider who does not have an agreement with the CMO for providing services in the LTC benefit package to members. The CMO shall arrange for services with non-CMO providers if the member's request is authorized by the CMO. Instances where the member's request for a non-CMO provider is warranted include:

- a. When the CMO does not have the capacity to meet the need;
- b. When the CMO does not have the specialized expertise, specialized knowledge or appropriate cultural diversity in its network of providers;
- c. When the CMO can not meet the need on a timely basis; or,
- d. When transportation or physical access to the CMO providers causes an undue hardship to the member.

4. *Member Choice of Interdisciplinary Teams*

The CMO shall allow a member to change interdisciplinary teams up to two times per calendar year if the CMO has additional interdisciplinary teams to offer the member.

5. *Provider Access Standards*

The CMO shall ensure all services and all service providers comply with access standards provided in Article III.B(9), *Providing, Arranging and Coordinating Services* (page 27).

B. Provider Network and Subcontracts

The term "subcontract" in this section refers to the definition provided in Addendum I, *Definitions* (page 105). The term does not apply to supplemental contracts between the CMO and DHFS. DHFS shall have sole authority to determine the conditions and terms of supplemental contracts between the CMO and DHFS.

1. *Administrative Costs*

In establishing provider and management subcontracts, the CMO shall seek to maximize the use of available resources and control costs.

2. *Subcontractor Audits*

CMO providers may be eligible for waivers of the audit requirements under s. 46.036(4) Wis. Stats., subject to approval by DHFS.

3. *Department's Discretion*

DHFS may approve, approve with modification, or deny subcontracts under this contract at its sole discretion. DHFS may, at its sole discretion and without the need to demonstrate cause, impose such conditions or limitations on its approval of a subcontract as it deems appropriate. DHFS may consider such factors as it deems appropriate to protect the interests of the State and members, including but not limited to, the proposed subcontractor's past performance.

4. *Legal Liability*

The CMO shall assure that all subcontracts shall not terminate legal liability of the CMO under this contract. The CMO may subcontract for any or all functions covered by this contract, subject to the requirements of this contract.

5. *Deadlines*

If DHFS requires the CMO to find a new subcontractor, the CMO shall secure a new subcontractor in 120 calendar days, and 60 calendar days to implement any other change required by DHFS. DHFS will acknowledge the approval or disapproval of a subcontract within 14 calendar days after its receipt from the CMO. Lack of such acknowledgment within 14 calendar days shall constitute approval.

6. *Member Provider Communications*

The CMO may not prohibit or otherwise restrict a provider from advising members about the long-term care and health care status of the member, or medical care and treatment for the member's condition or disease regardless of whether the service are services in or outside of the LTC benefit package if the provider is acting under the lawful scope of practice.

7. *Evidence of Service Capacity Before Effective Date of Contract*

By the effective date of this contract, the CMO shall have submitted its subcontracts or revisions to subcontracts previously approved, and obtained Department approval by one of two means: 1) the CMO submits each subcontract to DHFS for review and approval or disapproval, or 2) the CMO submits template language to DHFS planned for use in the CMO's subcontracts for Department review and approval or disapproval. After the CMO receives approval on templates, the CMO sends DHFS a certification stating the approved templates were used for each subcontractor. For each subcontractor the certification includes the subcontractor's name, service type and date of subcontract expiration. Any disapproval of subcontracts may result in the application by DHFS of remedies pursuant to Article VIII.L, *Remedies for Violation, Breach, or Non-Performance of Contract* (page 86).

By the effective date of this contract, the CMO shall demonstrate to DHFS an adequate capacity to provide the projected membership in the service area with: the appropriate range of services; access to prevention and wellness services; a sufficient number, mix and geographic distribution of providers of services; specialized expertise with the target population(s) served by the CMO; culturally competent providers (see F. *Cultural Competency*, page 62); and services that are physically accessible and available on a timely basis. Any CMO that will, at any time during the term of this contract, operate the CMO in a service area where the Family Care benefit has been available for at least 24 months, shall demonstrate capacity to provide services to all entitled persons who seek enrollment in the CMO.

The CMO shall develop standards for geographic access and timeliness of access to services in the LTC benefit package and member services that meet or exceed such standards as may be established by CMS or DHFS.

Evidence of adequate capacity to serve the membership is as follows:

- a. For all services in the LTC benefit package evidence of adequate capacity to serve the membership is by subcontractual relationships with providers or ability to provide the service directly.
 - b. For residential care facilities evidence of adequate capacity shall include identification of the availability of residential providers offering private rooms, and a process for moving an individual to a private room when one becomes available that is consistent with the member's preferences.
8. *Evidence of Service Capacity After Effective Date of Contract*
DHFS may review any and all subcontracts at any time.
- a. *Certification of Subcontracts*
An certification of subcontracts shall be submitted and receive Department approval before renewing this contract, and at any time DHFS determines there has been a significant change in the CMO's capacity to offer services in the LTC benefit package or in the CMO's projected membership. The certification shall include:
 - i. A statement that all of the required provisions of subcontracts are met (see 9. *Requirements for Subcontracts* below);
 - ii. A listing of the provider network (which consists of provider/agency name, location, services furnished by provider, and whether the provider is accepting new CMO members or not); and,
 - iii. Expiration date of all subcontracts.

- b. *Notices About Provider Changes*
Notices about changes in providers that are to be sent to members must be submitted to DHFS for approval and will be approved as soon as possible, but within 30 calendar days.
 - c. *Information to Members*
Upon the request of members, the CMO shall make available information about the identity, locations, qualifications, and availability of services in the LTC benefit package from providers that participate in the CMO.
 - d. *Timeliness and Quality of Services*
The CMO shall furnish services in the LTC benefit package promptly and without compromising quality of care.
 - e. *Monitoring Access to Services*
The CMO shall continuously monitor the extent to which it maintains an adequate capacity to provide the membership with the appropriate range of services, access to prevention and wellness services, a sufficient number, mix and geographic distribution of subcontractors of services, specialized expertise with the target population(s) served by the CMO before the effective date of the contract, culturally competent providers, (see F, *Cultural Competency*, page 62), and accessible services (meaning physically accessible, and available on a timely basis). The CMO shall take corrective action on deficiencies in any of these areas as necessary.
9. *Requirements for Subcontracts*
All subcontracts shall be in writing, shall include the provisions of this subsection, and shall include any general requirements of this contract that are appropriate to the service. The subcontractor must agree to abide by all applicable provisions of this contract. Subcontractor compliance with this contract specifically includes, but is not limited to, the following requirements (except for specific areas that are inapplicable in a specific subcontract):
- a. *Parties of the Subcontract*
The CMO and subcontractor entering into the agreement are clearly defined.
 - b. *Definitions*
Subcontract defines the terms that may be interpreted in ways other than what the CMO intends.
 - c. *Services*
Subcontract clearly delineates the services being provided, arranged, or coordinated by the subcontractor.

- d. *Compensation*
Subcontract specifies rates for purchasing services from the provider. Subcontract specifies payment arrangements in accordance with Article V.C(3), *Thirty-Day Payment Requirement* (page 58).
- e. *Term and Termination*
Subcontract specifies the start and end date of the subcontract and the means to renew, terminate and renegotiate. Subcontract specifies the CMO's ability to terminate and suspend the subcontract based on quality deficiencies and a process for the provider appealing the termination or suspension decision.
- f. *Legal Liability*
Subcontract agrees that no terms of the subcontract are valid which terminate legal liability of the CMO in accordance with Article VII.F, *Compliance with Applicable Law* (page 80).
- g. *QA/QI Programs*
Subcontractor agrees to participate in and contribute required data to the CMO's QA/QI programs as required in Article VI, *CMO Functions: Quality Assurance/Quality Improvement* (page 63).
- h. *Utilization Data*
Subcontractor agrees to submit CMO utilization data in the format specified by the CMO, so the CMO can meet DHFS specifications required by Article X, *Reports and Data* (page 92), and Addendum IV, *Reporting* (page 127).
- i. *Non-Discrimination*
Subcontractor agrees to comply with all non-discrimination requirements in Article VII.D, *Civil Rights* (page 77).
- j. *Insurance and Indemnification*
Subcontractor attests to carrying the appropriate insurance and indemnification.
- k. *Independent Contractor*
Subcontract recognizes the agreement is between two separate parties that are independently and freely entering into a subcontract.
- l. *Notices*
Subcontract specifies a means and a contact person for each party for purposes related to the subcontract (e.g. interpretations, subcontract termination).
- m. *Access to Premises*
Subcontractor agrees to provide representatives of the CMO, as well as duly authorized agents or representatives of DHFS and the Federal Department of Health and Human Services, access to its premises, and/or medical records in accordance with Article VII.I, *Access to Premises and Information* (page 82).

n. *Certification and Licensure*

CMO subcontractors and health care facilities agree to provide licensure, certification and accreditation status upon request of the CMO. Health professions which are certified by Medicaid (e.g. physical therapy) agree to provide information about their education, Board certification and recertification upon request of the CMO. Subcontractor agrees to notify the CMO of changes in licensure.

o. *Records*

Subcontractor agrees to comply with all applicable Federal and State record retention requirements.

p. *Member Records*

Subcontractor agrees to the requirements for maintenance and transfer of records stipulated in Article VII.B, *Member Records* (page 74). Subcontractor agrees to make records available to members and his/her authorized representatives within ten business days of the record request.

Subcontractors must forward records to the CMO pursuant to grievances within 15 business days of the CMO's request. If the subcontractor does not meet the 15-business day requirement, the subcontractor must explain why and indicate when the records will be provided.

Subcontractor agrees otherwise to preserve the full confidentiality of records in accordance with Article XIII, *Confidentiality of Records* (page 101).

q. *OSHA Requirement*

Subcontractor attests to meeting applicable OSHA requirements.

r. *Access to Services*

Subcontractor agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of services necessary to achieve outcomes that are in the LTC benefit package (e.g., Third Party Liability recovery procedures that delay or prevent care).

s. *Authorization for Providing Services*

Subcontract delineates the process the provider follows to receive authorization for providing services in the LTC benefit package to members. Subcontractor agrees to clearly specify authorization requirements to its providers and in any sub-subcontracts.

t. *Billing*

Subcontractor agrees not to bill a member for services in the LTC benefit package that received advance authorization from the CMO and were provided during the member's period of CMO enrollment. This provision shall continue to be in effect even if the CMO becomes insolvent.

u. *Appeals*

Subcontractor agrees to abide by the terms of Article V.C(5), *Appeals to the CMO and Department for Payment/Denial of Providers Claims* (page 58).

v. *Appeals and Grievances*

Subcontractor agrees to comply with the CMO's efforts regarding member's appeals and grievances that may involve the subcontractor.

10. *In establishing and maintaining subcontracts, the CMO must:*

- a. Establish mechanisms to ensure compliance by providers.
- b. Monitor providers regularly to determine compliance.
- c. Take corrective action if there is a failure to comply.

11. *Additional Requirements for Management Subcontracts*

Management subcontracts for administrative services will be subject to additional review to assure that rates are reasonable:

a. *Services and Compensation*

Subcontracts for CMO administrative services must clearly describe the services to be provided and the compensation to be paid.

b. *Bonuses, Profit-Sharing*

Any potential bonus, profit-sharing, or other compensation not directly related to costs of providing goods and services to the CMO, shall be identified and clearly defined in terms of potential magnitude and expected magnitude during the subcontract period.

c. *Reasonableness*

Any such bonus or profit-sharing shall be reasonable compared to services performed. The CMO shall document reasonableness.

d. *Limits*

A maximum dollar amount for such bonus or profit-sharing shall be specified for the subcontract period.

12. *Ownership*

The CMO agrees to submit to DHFS within 30 calendar days of the effective date of the contract, full and complete information as to the identity of each person or corporation with an ownership or control interest in the CMO, or any subcontractor in which the CMO has a 5% or more ownership interest.

a. *Definition of "Person with an Ownership or Control Interest."*

A "person with an ownership or control interest" means a person or corporation that:

- i. Owns, directly or indirectly, 5% or more of the CMO's capital or stock or receives 5% or more of its profits. The percentage of direct ownership or control is calculated by multiplying the percent of interest which a person owns by the percent of the CMO's assets used to secure the obligation. Thus, if a person owns 10% of a note secured by 60% of the CMO's assets, the person owns 6% of the CMO. The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns 10% of the stock in a corporation which owns 80% of the stock of the CMO, the person owns 8% of the CMO.
 - ii. Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the CMO or by its property or assets, and that interest is equal to or exceeds 5% of the total property and assets of the CMO; or,
 - iii. Is an officer or director of the CMO (if it is organized as a corporation) or is a partner in the CMO (if it is organized as a partnership).
- b. *Information to be Disclosed*
The following information must be disclosed:
- i. The name and address of each person with an ownership or controlling interest of 5% or more in the CMO or in any subcontractor in which the CMO has direct or indirect ownership of 5% or more;
 - ii. A statement as to whether any of the persons with ownership or control interest are related to any other of the persons with ownership or control interest as spouse, parent, child, or sibling; and,
 - iii. The name of any other organization in which the person also has ownership or control interest. This is required to the extent that the CMO can obtain this information by requesting it in writing. The CMO shall keep copies of all of these requests and responses to them, make them available upon request, and advise DHFS when there is no response to a request.
- c. *Potential Sources of Disclosure Information*
This information may already have been reported on Form HCFA-855, "Disclosure of Ownership and Control Interest Statement." Form HCFA-855 is likely to have been completed in two different cases. First, if the CMO is Federally qualified and has a Medicare contract, it is required to file Form HCFA-855 with CMS within 120 calendar days of the CMO's fiscal year end. Secondly, if the CMO is owned by or has subcontracts with Medicaid providers which are reviewed by the State survey agency, these providers may have completed Form HCFA-855 as part of the survey process. If Form HCFA-855 has not been completed, the CMO may supply the ownership and control information on a

separate report or submit reports filed with the State's insurance or health regulators as long as these reports provide the necessary information for the prior 12-month period.

As directed by the CMS Regional Office (RO), this Department must provide documentation of this disclosure information as part of the prior approval process for contracts. This documentation must be submitted to DHFS and the RO prior to each contract period. If the CMO has not supplied the information that must be disclosed, a contract with the CMO is not considered approvable for this period of time and no full Federal participation is available for the period of time preceding the disclosure.

d. *Prohibited Providers*

The CMO may not knowingly have a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities as a director, officer, partners, or person with a beneficial ownership of more than 5% of the entity's equity, or have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the CMO's obligations under this contract.

13. *Business Transactions*

The CMO shall disclose to DHFS information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act. (See Sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Act.) Definition of a Party in Interest. As defined in Section 1318(b) of the Public Health Service Act, a party in interest is:

- a. Any director, officer, partner, or employee responsible for management or administration of a CMO; any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the CMO; any person who is the beneficial owner of more than 5% of the CMO; or, in the case of a CMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law; or
- b. Any organization in which a person described in subsection (a) is director, officer or partner; has directly or indirectly a beneficial interest of more than 5% of the equity of the CMO; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the CMO;
- c. Any person directly or indirectly controlling, controlled by, or under common control with the CMO; or
- d. Any spouse, child, or parent of an individual described directly above in a, b or c.

14. *Types of Transactions Which Must Be Disclosed*

Business transactions which must be disclosed include:

- a. Any sale, exchange or lease of any property between the CMO and a party in interest;
- b. Any lending of money or other extension of credit between the CMO and a party in interest; and,
- c. Any furnishing for consideration of goods, services (including management services) or facilities between the CMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of his/her employment.

The information which must be disclosed in the transactions listed directly above between the CMO and a party in interest includes:

- i. The name of the party in interest for each transaction;
- ii. A description of each transaction and the quantity or units involved;
- iii. The accrued dollar value of each transaction during the fiscal year; and,
- iv. Justification of the reasonableness of each transaction.

If this contract is being renewed or extended, the CMO shall disclose information on these business transactions which occurred during the prior contract period. If the contract is an original contract with DHFS, but the CMO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving the Medicaid enrollment. All of these CMO business transactions must be reported.

The CMO shall notify DHFS within seven calendar days of any notice given by the CMO to a subcontractor, or any notice given to the CMO from a subcontractor, of a subcontract termination, a pending subcontract termination, or a pending modification in subcontract terms, that could reduce member access to care.

If DHFS determines that a pending subcontract termination or pending modification in subcontract terms will jeopardize member access to care, then DHFS may invoke the remedies provided for in Article VIII.L, *Remedies for Violation, Breach, or Non-Performance of Contract* (page 86). These remedies include contract termination (with notice to the CMO and an opportunity to correct provided for), and suspension of new enrollment.

The CMO shall submit MOUs referred to in this contract to DHFS upon DHFS's request.

The CMO shall submit copies of changes in MOUs to DHFS within 15 calendar days of the effective date of the contract.

C. Payment to Providers

1. Allowable Cost Policy Not Applicable

In subcontracting with and paying providers, the CMO is not subject to s. 46.036 (3) and (5m), Wis. Stats., which refer to allowable costs. The CMO may expend funds from the per member per month payment rates on a subcapitated basis.

2. Medicaid Rates

The CMO shall not pay its providers more than the Medicaid fee-for-service rates for Medicaid covered services in the LTC benefit package unless DHFS approves a higher level of payment. DHFS will base the approval on whether the service will result in added quality or value, or if the availability of service providers at the Medicaid fee-for-service rate is not sufficient.

3. Thirty Day Payment Requirement

The CMO shall pay at least 90% of clean claims from subcontractors for services in the LTC benefit package that receive advance authorization from the CMO within 30 calendar days of receipt of bill, and 99% within 90 calendar days, except to the extent subcontractors have agreed to later payment. The CMO agrees not to delay payment to subcontractors pending subcontractor collection of third party liability (TPL) unless the CMO has an agreement with their subcontractor to collect TPL.

4. Claims Retrieval System

The CMO shall maintain a claims retrieval system that can, on request, identify date service was received, action taken on all provider claims (i.e., paid, denied, other), and when action was taken. The CMO shall date stamp all provider claims upon receipt.

5. Appeals to the CMO and Department for Payment/Denial of Providers Claims

The CMO shall:

- a. Provide the name of the person and/or function at the CMO to whom provider appeals should be submitted.
- b. Provide written notification to providers of the CMO payment/denial determinations. These notifications will include:
 - i. A specific explanation of the payment amount or a specific reason for the payment denial;

- ii. A statement regarding the provider's rights and responsibilities in appealing the CMO's initial determination by submitting a separate letter or form which:
 - Is clearly marked "appeal";
 - Contains the provider's name, date of service, date of billing, date of rejection, and reason(s) claim merits reconsideration for each appeal; and,
 - Is submitted to the person and/or function at the CMO that handles Provider Appeals within 60 calendar days of the initial denial or partial payment.
- iii. A statement advising the provider of the provider's right to appeal to DHFS if the CMO fails to respond to the appeal (as indicated directly above) within 45 calendar days, or if the provider is not satisfied with the CMO's response to the request for reconsideration. All appeals to DHFS must be submitted in writing within 60 calendar days of the CMO's final decision to DHFS as follows:

**Contract Administrator
Center for Delivery Systems Development
1 South Pinckney Street, Suite 340
PO Box 1379
Madison, WI 53701-1379**

- c. Accept written appeals from providers who disagree with the CMO's payment/denial determination, if the provider submits the dispute in writing within 60 calendar days of the initial payment/denial notice. The CMO has 45 calendar days from the date of receipt of the request for reconsideration to respond in writing to the provider. If the CMO fails to respond within that time frame, or if the provider is not satisfied with the CMO's response, the provider may seek a final determination from DHFS.
- d. Accept DHFS's determinations regarding appeals of disputed claims. In cases where there is a dispute about the CMO's payment/denial determination and the provider has requested a reconsideration by the CMO according to the terms described above, DHFS will hear appeals and make final determinations. These determinations may include the override of the CMO's time limit for submission of claims in exceptional cases. DHFS will not exercise its authority in this regard unreasonably. DHFS will accept written comments from all parties to the dispute prior to making the decision. Appeals must be submitted to DHFS within 60 calendar days of the date of written notification of the CMO's final decision resulting from a request for reconsideration. DHFS has 45 calendar days from the date of receipt of all written comments to respond to these appeals. The CMO shall pay provider(s) within 45 calendar days of receipt of DHFS's final determination.

D. Employment Practices

1. *Competency Standards*

The CMO shall set competency standards for CMO staff providing services in the LTC benefit package. The CMO shall provide or arrange for training for such CMO employees to meet competencies. The CMO shall establish a system for monitoring CMO staff providing services in the LTC benefit package to assure for the provision of quality services. Refer to Article VI.C, *Provider Selection and Retention* (page 67) for related employee standards.

2. *Family Members*

A person in the member's family (except for the spouse of a member) shall be paid by the CMO for services if all of the following apply:

- a. The service is authorized by the interdisciplinary team.
- b. The member's preference is for the family member to provide the service.
- c. The family member meets the CMO's standards for its subcontractors or employees providing the same service.
- d. The family member will either:
 - i. Provide an amount of service that exceeds normal Family Care giving responsibilities for a person in a similar family relationship who does not have a disability; or,
 - ii. Find it necessary to forego paid employment in order to provide the service and is not receiving a pension (including Social Security retirement benefits).

3. *Intimate Care Services*

If the CMO is the employer of attendants for the purposes of supportive home care, personal care or home health aid services the following conditions shall be met:

- a. Members are offered the opportunity to participate with the CMO in choice and assignment of attendant(s) that provide the service;
- b. Members are involved with training the CMO attendant(s) (if desired by the member);
- c. Members are involved in negotiating hours (e.g. time of day) of services;
- d. Members regularly participate in the evaluation of services provided by their CMO attendant(s); and,

- e. Members are involved in the supervision of CMO attendant(s) along with the CMO attendant supervisor (if desired by the member, and to the extent of his/her abilities).
- 4. *Member Employs Attendants*
The member shall have the opportunity to directly be the employer of attendants for supportive home care services as specified in HFS 73.06 and 73.08 Wis Admin. Code.
- 5. *Federal Department of Labor*
The CMO shall implement and adhere to rules and regulations prescribed by the United States Department of Labor and in accordance with 41 Code of Federal Regulations, Chapter 60.
- 6. *Criminal Background Checks*
The CMO shall comply with regulations of the United States Department of Labor recited in 20 Code of Federal Regulations, Part 741 and the Federal Rehabilitation Act of 1973. The CMO shall ensure compliance by any and all subcontractors engaged by the CMO under this contract with said regulations.

The CMO is an entity certified by the state and shall comply with HFS12 related to criminal background and other checks.

All requirements of HFS 12 pertain to any providers or CMO staff who come into direct contact with a member, including:

- a. The CMO shall establish and implement a policy consistent with HFS 12, to appropriately respond when there is a criminal conviction related for a person who is to be paid to provide services to a member;
- b. The CMO shall perform, or require providers to perform, criminal background checks on people paid to provide services to a member in accordance with HFS 12;
- c. For CMO provider organizations that have staff providing services that result in direct contact with CMO members, the CMO shall ensure criminal background checks are completed in accordance with HFS12;
- d. The CMO maintains the ability to not pay any provider if the CMO deems it is unsafe based on the findings of past criminal convictions stated in the criminal background check; and,
- e. The criminal background check shall be made available to the member or entity that is the employer.

E. Provider Certification

1. Provider Standards

The CMO shall use only providers that:

- a. Meet the provider standards in Wisconsin's Family Care Home and Community-Based Waivers and are consistent with any applicable DHFS policies and procedures, including the use of certified RCACs and certified adult day care; or,
- b. Are certified by the Medicaid program for those services in the LTC benefit package that would have been provided under Medicaid fee-for-service; or,
- c. Meet the CMO's provider standards, which are approved by the State.

2. Information to Members

The following information shall be furnished by the CMO upon the request of a member:

- a. The licensure, certification and accreditation status of the managed care organizations and providers in the CMO's provider network; and,
- b. The education, board certification and recertification of health professions which are certified by Medicaid (e.g. physical therapy).

F. Cultural Competency

1. Cultural Values

The CMO shall incorporate in its policies, administration, provider contract, and service practice the values of honoring members' beliefs, being sensitive to cultural diversity, and fostering in staff/providers attitudes and interpersonal communication styles which respect members' cultural backgrounds. The CMO shall have specific policy statements on these topics and communicate them to subcontractors.

2. Cultural Competency

The CMO shall encourage and foster cultural competency among CMO staff and providers.

3. Cultural Preference

The CMO shall permit members to choose providers from among the CMO's network based on cultural preference.

4. Appeals and Grievances

The CMO shall accept appeals and grievances from members related to a lack of access to culturally appropriate care. Culturally appropriate care is care delivered with sensitivity, understanding, and respect for the member's culture.

G. Reproduction and Distribution of Materials

The CMO shall, at the CMO expense, reproduce and distribute information or documents sent to the CMO from DHFS that contain information providers must have in order to fully implement this contract. These materials shall be distributed within a reasonable time frame stipulated by DHFS.

VI. CMO Functions: Quality Assurance/Quality Improvement

A. QA/QI Plan, Program, and Coordination

1. *QA/QI Plan*

The CMO's governing board or its designee shall approve a written QA/QI work plan that outlines the scope of activity and the goals, objectives, and timelines for the QA/QI program. This QA/QI plan must be submitted to DHFS and approved before the effective date of the contract (i.e. the first Health and Community Supports contract between the CMO and DHFS). The CMO's governing board or its designee shall annually review and approve the CMO's updated QA/QI work plan that outlines the scope of ongoing activities and the goals, objectives, and timelines for the QA/QI program. The CMO's governing board or its designee shall set new goals and objectives annually based on findings from quality assurance and improvement activities.

2. *QA/QI Program*

The CMO QA/QI program shall include the following basic activities: (1) conduct performance improvement projects, (2) processes to monitor and detect underutilization and overutilization of services, and (3) processes to monitor and assess the quality and appropriateness of care furnished to Family Care members. In addition, the CMO shall maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the CMO's QA/QI program. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of eligibility for financial reasons.

The CMO shall implement a QA program to assure that the quality of care and services it provides either through CMO staff or sub-contracted providers is maintained at acceptable levels. The scope of activities to assure quality must include: potential problem identification through screening; verifying quality-related problems and causes; evaluation of problems to determine severity and whether or not further study is warranted by audit or other means; designing activities to address deficiencies; recommending corrective action plans; assuring the implementation of corrective action plans; and conducting follow-up activities to determine whether or not care meets acceptable standards.

The CMO shall implement an effective QI program that aims to achieve significant improvement sustained over time, through ongoing measurements and CMO interventions, related to member health, functioning and satisfaction. Significant

improvement for a particular indicator is defined either as reaching a specific target or as improving performance by a fixed percentage defined in advance by the CMO, or by DHFS. The CMO shall evaluate the overall effectiveness of its QA/QI program annually to determine whether the program has achieved significant improvement, where needed, in the quality of service provided to its members.

3. *Department Review and Audit*

The CMO's organizational structure, standards, policies and practices shall allow for individualization to achieve member-defined outcomes. Whenever possible, the CMO shall demonstrate a direct connection between organizational actions and member defined outcomes. DHFS will determine the effectiveness of the CMO by evaluating its progress towards achieving personal outcomes for its members. On an annual basis, DHFS shall draw a random sample of all CMO members enrolled, for voluntary participation in the Family Care member outcome interviews. The CMO shall designate a staff person to act as an interview scheduler. The CMO scheduler will contact all members in the CMO sample and arrange member interviews and follow up interviews with the member's primary care manager, according to guidelines forwarded by DHFS. Upon conclusion of the interviews, DHFS shall generate a report based on the results of all of the member outcome interviews and forward the report to the CMO. DHFS shall also forward CMO specific results on the presence or absence of the member-defined outcomes and supports provided to the CMO in a computerized spreadsheet format. The CMO shall use their specific results on member outcomes in conjunction with data from their provider network, claims data, etc. to conduct further analysis to assist in the identification of QA/QI performance improvement efforts.

The CMO shall have documentation of all aspects of the QA/QI program available for Department review upon request. DHFS may perform off-site and on-site QA/QI audits to ensure that the CMO is in compliance with the requirements of this contract. The review and audit may include: on-site visits; staff and member interviews; record reviews; review of QA/QI procedures, reports, committee activities, corrective actions and follow up plans; peer review process; review of the results of the member satisfaction surveys; and review of CMO staff and provider qualifications.

4. *QA/QI Performance*

The CMO shall achieve required minimum levels of performance on specific measures that may be established and shall submit data specified by the DHFS that enables the DHFS to measure the CMO's performance. The CMO shall measure and report such performance to DHFS, using standard measures required by the DHFS or any national performance measures and levels that may be identified and developed by CMS in consultation with States and other relevant stakeholders. The CMO shall meet any goals for performance improvement on specific measures that may be established by DHFS or CMS. See Addendum II, *CMO Quality Indicators* (page 114) for more information.

5. *QA/QI Administrative Structure*

The CMO's QA/QI program shall be administered through clear and appropriate administrative arrangements, such that:

- a. The governing board oversees and is accountable for the QA/QI program.
- b. A designated senior manager, who has direct authority to commit CMO resources to the QA/QI effort, is responsible for QA/QI implementation.
- c. The staffing level and available resources shall be sufficient to provide reasonable assurance that compliance with QA/QI standards are achieved within the maximum permissible time frame (a period to be established by DHFS).
- d. A QA/QI committee or other coordinating structure (that includes both administrative personnel and providers) shall exist to clearly identify individuals or organizational components responsible for each aspect of the QA/QI program and ensure that effective organizational structures are in place to facilitate communication and coordination.
- e. The QA/QI program shall include active participation by:
 - i. Members or other individuals who meet the functional eligibility for the CMO's target population(s);
 - ii. CMO staff and providers, including attendants and informal caregivers who are able to contribute to the QA/QI effort; and,
 - iii. Long-term care and health care providers with professional expertise appropriate to the services offered by the CMO.
- f. There shall be a collaboration among all aspects of the QA/QI activity and other functional areas of the CMO impacting the quality of service delivery and clinical care (e.g., utilization management, risk management, appeals and grievances, etc.).

6. *QA/QI Program Records*

The activities of the QA/QI program shall be documented. These documents shall be available to DHFS upon request.

7. *Delegation*

The CMO shall oversee and be wholly accountable for any functions or responsibilities that are described in these QA/QI standards and are delegated to any subcontractor. Specific responsibilities of the CMO are:

- a. Before any delegation, the CMO shall evaluate the prospective subcontractor's ability to perform the activities to be delegated;

- b. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the subcontractor and provides for revocation of the delegation or imposition of other sanctions if the subcontractor's performance is inadequate;
- c. The CMO shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review at least once a year;
- d. If the CMO identifies deficiencies or areas for improvement, the CMO and the subcontractor shall take corrective action.

8. *Performance Improvement Project*

During the first two consecutive contract periods, the CMO shall initiate each year one or more performance improvement projects among the required focus and outcome areas specified in this contract and report the status and results of each such project to the State as requested. During the third and subsequent contract periods, the CMO shall have, at a minimum, two performance improvement projects underway that address the required focus and outcome areas specified in this contract.

Each performance improvement project must be completed (i.e. fully implemented) in a reasonable time period. The reasonable time period for a single performance improvement project is four years. The sequence of expected activities during this time frame is:

- Year 1 – Select topic, identify target population, purpose, identify quality indicators and describe the baseline data collection methodology to be used,
- Year 2 – Collect, analyze and interpret baseline data
- Year 3 – Plan and implement improvement activities/interventions, and evaluate whether or not improvement occurred (i.e. repeat data collection, analyze and interpret remeasurement)
- Year 4 – Continue implementation of improvement activities, repeat re-measurement, and reevaluation

Annually, the CMO shall provide to the State the status and results of each project. Specifically, from performance improvement projects underway or information on projects that have been initiated, the CMO must report new information in enough detail to show that the CMO is progressing towards full implementation of each project.

The Department as part of its review of the impact and effectiveness of the CMO's internal quality assurance and quality improvement program shall review the results of the CMO's performance improvement projects at least annually. The requirements for the Performance Improvement Projects are addressed in Addendum IX, *Performance Improvement Projects* (page 139).

B. Member Input

1. Communication Processes

The language and practices of the CMO shall recognize each member as an individual and emphasize each member's capabilities. CMO staff shall demonstrate dignity and respect their interactions with members.

2. Ongoing Member Participation

The CMO shall create a means for members to continually participate in CMO quality improvement and give input and feedback on the quality of the CMO services. Some methods for this ongoing member participation, feedback and input include: focus groups; consumer advisory councils; member participation on the governing board; the QA/QI committee or other committees; surveys of members who disenrolled; or task forces related to evaluating services. The CMO shall reach out to diverse member populations, such as frail, homebound members, to provide opportunities for participation, input, or feedback. Documentation of outreach efforts to solicit feedback from members shall be available to DHFS upon request.

3. Annual Member Feedback on CMO Performance

In addition to the ongoing member participation described above, at least annually the CMO must seek formal member input, through member surveys, face-to-face interviews or other means, on:

- a. The effectiveness of its communications with members;
- b. Access and availability for services in and outside of the LTC benefit package;
- c. Choice and continuity;
- d. Changes in functional and health status of members; and,
- e. Other information of interest to consumers.

The results of the annual member feedback on CMO performance shall be made available to DHFS and members upon request. The purpose of this activity is to identify successes, potential problems and barriers to care and to provide potential members with information they need to choose a CMO.

The CMO shall have systems in place for acting on member feedback in a timely way, and shall report to DHFS the results and any quality management projects planned in response to the results. The annual member feedback activity can be used to obtain information for a Performance Improvement Project, as discussed in Addendum IX, *Performance Improvement Projects* (page 139).

C. Provider Selection and Retention

The CMO shall implement a provider selection and retention process that meets the requirements of this section.

1. For all providers who have signed contracts or participation agreements the initial selection process and reassessment at specified intervals shall be accomplished to ensure that, at a minimum, the provider is licensed (if DHFS requires licensing to operate in the State) and is in compliance with any other Federal or State requirements.
2. That the CMO monitors the performance of providers on an ongoing basis and through a process that updates information obtained during the initial selection process and considers performance indicators, including those obtained through the following:
 - The QA/QI program;
 - The utilization management system;
 - The appeal and grievance system;
 - Member satisfaction surveys; and,
 - Other CMO activities.
3. If the CMO identifies deficiencies or areas for improvement, the CMO and the provider take corrective action.
4. Discrimination Prohibited
The CMO's use of formal selection and retention criteria shall not discriminate against particular practitioners or other providers, such as those who serve high risk populations, or specialize in conditions that require costly treatment.
5. The CMO may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

D. Availability of Member Records

Member records must be readily available for CMO-wide QA/QI and Utilization Management activities. (See following section, *Authorization of Services and Utilization Management*.)

E. Authorization of Services and Utilization Management

The CMO shall have documented policies and procedures for processing requests for initial and continuing authorizations of services and for determining approval or denial of services. These policies require review and approval by DHFS before the effective date of this contract. These policies shall be stated in the Member Handbook.

CMO service authorization policies and procedures shall address requests for services made by a member directly to a member of the interdisciplinary team and requests made by a member or a provider on behalf of the member through the CMO's utilization management system.

1. *Authorization of Services*

Family Care members have a right to request any covered service, whether or not the service has been recommended as necessary or appropriate by a professional or the interdisciplinary team responsible for coordinating their care. The CMO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, disability or condition. Policies must take into account anticipated long-term social and quality of life issues. Such consideration includes implications for independent living, support for the least restrictive residential setting for the member, and skill acquisition for the member to perform activities of daily living.

2. *Direct Requests by a Member for a Service from the Interdisciplinary Team*

When a member requests a service from a team member the CMO shall direct the team through written policies and procedures to:

- a. Promptly determine whether the request is to be authorized by the interdisciplinary team or whether the request must be referred outside the team for review, on the basis of review criteria that is approved by the state, and approval (see number 5. below for processing requests outside the team);
- b. If the team is authorized by the CMO to provide or arrange the requested service without referring the request to anyone else, the team must use a standardized decision making guideline when processing requests for services that has been approved by the Department. (Requests for approval of the Resource Allocation Decision Method (RAD), as developed and disseminated by DHFS, when used by the interdisciplinary team and, including the member, will be approved by DHFS as a service authorization policy.);
- c. Acknowledge receipt of the request and explain to the member the process to be followed in processing the request;
- d. Assist the member as needed in completing forms or taking other necessary steps to process the request;
- e. For requests that the team is authorized to provide or arrange, assure that any such requests result in either a prompt decision by the team to approve or to disapprove provision of or authorization of the service (based on either the RAD and/or other Department approved decision-making method);
- f. When the CMO requires that additional CMO employees (e.g., supervisor) be involved in decision-making about a member request for service, the CMO employee shall:
 - i. Join with the interdisciplinary team,
 - ii. The team shall use the RAD or other approved decision-making method, and,

- iii. The member's interdisciplinary team shall make the final decision taking into consideration the recommendations of the CMO employee;
 - g. For requests that must be referred outside the team for authorization, assure that such a referral occurs promptly.
3. *Process Direct Requests that are Determined to be not Necessary or Appropriate*
If the team is authorized by the CMO to provide or arrange the requested service without referring the request to anyone else and the team determines that the service is not necessary or appropriate and therefore declines to provide or authorize the service, the CMO shall:
- a. That the decision is made in consultation with appropriate health care professionals who have appropriate clinical expertise in treating the member's condition or disease.
 - b. Give the member written notice of any decision by the team to deny a request, or to authorize a service in an amount, duration, or scope that is less than requested. Service authorization decisions not reached within the timeframes specified below constitute a denial and therefore require a written notice). Written notice must be given on the date that the timeframes expire. [The notice must meet the requirements of Notice of Action (page 39).]
 - c. Notify the requesting provider of the authorization decision. Notices to providers need not be in writing.
 - d. Make decisions on direct requests for services and provide notice as expeditiously as the member's health condition requires and within any state-established timeframes that may not exceed 14 calendar days following receipt of the request for the service, with a possible extension of up to 14 additional calendar days, if the member, or the provider, requests extension.
4. *Service Requests that the CMO Requires a Referral Outside the Team*
The CMO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for the purpose of utilization management, provided the services furnished can reasonably be expected to achieve outcomes as defined in Addendum I, *Definitions*, page 105.
5. *Authorization Decisions Made Outside the Interdisciplinary Team*
For authorization decisions that the team is required to refer to anyone else (including referring the request to the team's immediate supervisor), and authorization requests that are made by a member or a provider through an CMO's utilization management system, the CMO shall:

- a. Use review criteria for decisions on coverage, necessity and appropriateness that are clearly documented, are based on reasonable evidence or a consensus of relevant practitioners, and are regularly updated.
- b. Specify information required for advance authorization decisions, have mechanisms to ensure consistent application of review criteria for advance authorization decisions, and consult with the requesting provider when appropriate.

6. *Timeframe for Expedited Authorization Decisions*

- a. Policies shall specify time frames for responding to requests for initial and continued determinations as expeditiously as the member's situation requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if the member, or the provider, requests extension.
- b. For cases in which a provider indicates, or the CMO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CMO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. The CMO may extend the 72-hour time period by up to 14 calendar days if the member requests extension.
- c. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a professional who has appropriate expertise in treating or managing the member's condition or disease.
- d. All service requests that are denied, limited, or discontinued shall be recorded, along with the disposition. Aggregate data on service requests that are denied, limited, or discontinued are compiled for use in quality assessment and monitoring and are available upon request by DHFS.
- e. The CMO shall communicate to providers, upon request, criteria used for review and approval of specific services.
- f. The CMO does not prohibit providers from advocating on behalf of members within the utilization management process.
- g. The CMO shall provide that compensation to individuals or entities that conduct utilization management or prior authorization activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue services necessary to achieve outcomes to any enrollee.

7. *Notice of Decisions*

The CMO shall provide written notification to the member when a decision is made to deny or limit a member's request for a service; or to terminate, reduce, or suspend a current service; or to deny payment for a service. Service authorization decisions not reached within the timeframes specified below constitute a denial and are thus require a written notice. Written notice must be given on the date that the timeframes expire. (The notice must meet the requirements of Article IV.G(3), *Notice of Action* (page 39).

The CMO shall provide written notification to the provider when a decision is made to not act on a claim (i.e., pay or deny) for services in the timeframe previously agreed upon with the provider. (See Article V.C(5), *Appeals to the CMO and Department for Payment/Denial of Providers Claims*, page 58, for related information).

F. External Quality Review

1. *Assistance to Department and External Quality Review*

The CMO shall assist DHFS and the external quality review organization under contract with DHFS in identification of provider and member information required to carry out on-site or off-site member record reviews. The provider of service may elect to have member records reviewed on-site or off-site.

2. *CMO's Tasks*

When the external quality review organization under contract with DHFS identifies quality deficiencies which need to be followed up on, the CMO shall be responsible for the following tasks:

- a. Assign a staff person(s) to conduct follow-up with the CMO manager or the CMO provider(s) concerning each quality deficiency identified by DHFS's external quality review organization, including informing the provider(s) of the finding and monitoring the provider's resolution of the finding. Follow up with the appropriate CMO manager is conducted when the service is directly provided by the CMO. Follow up with the CMO provider is conducted when the service is subcontracted;
- b. Inform those participating in the CMO's QA/QI program of the follow up activities and final findings. Involve those participating in the QA/QI program in the development, monitoring, and resolution of the corrective action plan; and,
- c. Submit a corrective action plan or an opinion in writing to DHFS within 60 calendar days that describes the measures that the CMO and the provider intend to take to resolve the finding. The CMO's final resolution of all potential Quality Improvement cases must be completed within six months of the notification to the CMO. A case is not considered resolved by DHFS until DHFS approves the response submitted by the CMO and provider.

3. *Training*

The CMO shall facilitate training provided by DHFS to the CMO's providers.

4. *Availability of Results*

The results of the review shall be made available to DHFS, CMO providers, and members in a manner that does not disclose the identity of any individual member.

VII. CMO Functions: Administration

A. Financial Management

1. *Elements of Financial Management*

The CMO is responsible for sound financial management practices which maximize the value and quality of services provided for the funds expended. The CMO's financial management systems shall include the following at a minimum:

- a. Systems to ensure that information used for financial management and reporting purposes is timely, accurate and complete;
- b. An accounting system adequate to manage the business needs of a managed care organization;
- c. Policies and procedures, including innovative practices, to ensure effective cost control;
- d. Policies and procedures regarding the accumulation and appropriate utilization of the solvency protections as specified in Addendum III, *Capacity for Financial Solvency*, (page 122); and,
- e. Practices to ensure the cost-effective use of available resources, including per member per month payments (Article IX.A, *Per Member Per Month Payment Rates*, page 90), Medicare and other third party liability payment sources (Article IX.F, *Third Party Liability (TPL)*, page 90), 1915(c) waiver post eligibility treatment of income (Article III.A(8), *Billing Members*, page 18), and private pay case management (Article III.A(10), *Private Pay Care Management*, page 19).

2. *Business Plan*

The CMO shall develop or update a three-year business plan which receives approval from DHFS prior to the effective date of this contract. The business plan or update shall contain the following elements at a minimum:

- a. Monthly enrollment plan of census projections, showing the CMO's steps toward serving the target population(s) in a timeframe agreed upon with DHFS. The CMO shall submit an updated enrollment plan prior to the end of this contract period, and receive Department approval of the plan before the effective date for the subsequent contract period;

- b. Monthly budget projections, including detailed member service costs, care management costs, administrative expenses including plans for additional interdisciplinary teams and other staff necessary to serve the added enrollment, expenses for Information Technology improvements, all other indirect and direct administrative costs;
- c. Monthly revenue projections. (Both b. & c. should be in the CMO Income Statement format which the CMO plans to use for 2003 so that budget vs. actual statements can be generated monthly;)
- d. Business plan update should include a summary of the major strategic initiatives for the upcoming contract year including, cost savings initiatives, staffing initiatives, technology improvement initiatives etc. along with associated costs/benefits of the initiatives; and,
- e. Business plan updates shall include a summary of the CMO's ability to implement the business plan approved for the prior contract period and explanation of requests for any variances or amendments to the business plan requested for the current contract period.

B. Member Records

The CMO shall have a system for maintaining member records and for monitoring compliance with their policies and procedures.

1. Confidentiality

The CMO shall implement specific procedures to assure the confidentiality of health and medical records and of other personal information about members, including:

- a. Members have the right to approve or refuse the release of personally identifiable information, except when such release is authorized by law;
- b. Original medical records shall be released only in accordance with federal or state law, or court orders or subpoenas;
- c. Copies of records and information from the CMO shall be released only to authorized individuals; and,
- d. Unauthorized individuals shall be prohibited from gaining access to, or altering, member records.

2. Member Access to Records

Members shall have access to their records in accordance with applicable state or federal law. The CMO shall use best efforts to assist a member, his/her authorized representatives, and others designated by the member to obtain records within ten business days of the request. The CMO shall identify an individual who can assist the member and his/her authorized representatives in obtaining records.

3. *Medical Information Available to CMOs*

The CMO is a contractor of the State and is therefore entitled to obtain records according to Wisconsin Administrative Code, HFS 104.01(3), on Confidentiality of Medical Information. DHFS requires Medicaid-certified providers to release relevant records to the CMO to assist in compliance with this section. Where the CMO has not specifically addressed photocopying expenses in their provider, subcontracts or other arrangements, the CMO is liable for charges for copying records only to the extent that DHFS would reimburse on a fee-for-service basis.

4. *Care of Records*

Member records shall be accurate, legible and safeguarded against loss, destruction, or unauthorized use.

5. *Maintain Complete Records*

Documentation in member records must reflect all aspects of care, including documentation of assistance with transitional care in the event of a disenrollment. In cases involving the death of a member, the date, place and time when the member expired, the cause of death (if known) and the immediate events preceding the death must be recorded in the member record by the CMO. Member records must be readily available for member encounters, for administrative purposes.

6. *Professional Standards*

The CMO shall maintain, or require the CMO subcontractors to maintain, individual member records in accordance with established professional standards, for each member. The CMO shall make all pertinent and sufficient information relating to the management of each member's medical and long-term care readily available to DHFS and to appropriate health professionals.

7. *Procedure for Transfer of Records*

The CMO shall have procedures to provide for prompt transfer of records to other non-CMO providers for the management of the member's medical and long-term care, and the appropriate exchange of information among the CMO and non-CMO providers receiving referrals.

8. *Records Available for QA/QI and Utilization Review*

Member records shall be readily available for CMO-wide QA/QI and Utilization Review activities. The member records shall provide adequate medical and long-term care service information, and other clinical data needed for QA/QI and Utilization Review purposes, and for investigating member appeals and grievances.

9. *Continuity of Records*

The CMO shall have adequate information and record transfer procedures to provide continuity of care when members are treated by more than one provider.

10. *Contents of Member Records*

A member record shall contain at least the following items:

- a. Face Sheet of demographic information;
- b. LTC Functional Screen (most current screen);
- c. Level of Care determination;
- d. Consent forms;
- e. Family Care Comprehensive Health Assessment;
- f. Family Care Comprehensive Social Assessment;
- g. Documentation of re-assessment(s);
- h. Individual Service Plan;
- i. Member-Centered Plan;
- j. Advance directive (if there is one completed);
- k. Guardianship, power of attorney (if there is one completed);
- l. Case notes by CMO interdisciplinary team members;
- m. Cost share forms/documentation (if there is any);
- n. Notice of Change forms (if there are any);
- o. Signed Enrollment Request; and,
- p. Reports of consultations.

Minimum member record documentation per chart entry or encounter must conform to the Wisconsin Administrative Code, Chapter HFS 106.02(9)(b), Medical and Financial Record keeping, and to HFS 107.32(1)(d), Case Management Services when applicable to the member encounter.

C. Accessibility of Language

The CMO shall provide materials in formats accessible due to language spoken and various impairments, including but not limited to Braille and large print. Materials shared with potential members and members shall be understandable in language and format based on the following:

1. Material directed at a specific member (e.g. written communication of intention to deny a service): shall be in the language understood by the individual.

2. Material directed at potential members or members in general (e.g. member handbook): shall be provided in languages prevalent in the CMO service area, and in accessible formats (e.g. Braille, large print).
3. All materials: shall be in easily understood language and format. Materials shall take into account individuals with limited reading proficiency.
4. The CMO shall provide instructions to members and potential members in the materials on how to obtain information in the appropriate language or accessible format (e.g. sign language) and how to access such translation/interpreter services.

D. Civil Rights

1. Civil Rights Action Plan

The CMO assures that it has submitted to DHFS's Affirmative Action/Civil Rights Compliance Office a current copy of its two-year Civil Rights Compliance Action Plan for Meeting Equal Opportunity Requirements under Title VI and VII of the Civil Rights Act of 1964, Sections 503 and 504 of the Rehabilitation Act of 1973, Title VI and XVI of the Public Health Service Act, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Omnibus Reconciliation Act of 1981, the Americans with Disabilities Act (ADA) of 1990, and the Wisconsin Fair Employment Act. If a Plan was reviewed and approved during the previous year, a plan update must be submitted for this contract period.

2. Discrimination in Services Prohibited

No otherwise qualified person shall be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination in any manner on the basis of race, color, national origin, sexual orientation, religion, sex, disability or age. This policy covers eligibility for and access to service delivery, and treatment in all programs and activities. All employees of the CMO are expected to support goals and programmatic activities relating to nondiscrimination in service delivery.

3. Employment Discrimination Prohibited

Except where s. 111.337 Wis. Stat. applies, no otherwise qualified person shall be excluded from employment, be denied the benefits of employment or otherwise be subject to discrimination in employment in any manner or term of employment on the basis of age, race, religion, sexual orientation, color, sex, national origin or ancestry, handicap (as defined in Section 504 and the ADA), arrest or conviction record, marital status, political affiliation, or military participation. All employees are expected to support goals and programmatic activities relating to non-discrimination in employment.

4. Equal Opportunity Policy

The CMO shall post the Equal Opportunity Policy, the name of the Equal Opportunity Coordinator and the discrimination complaint process in conspicuous places available to applicants and people who use the CMO's services, and applicants for employment and employees. The complaint process will be according to

Department standards and made available in languages and formats understandable to applicants, people who use the CMO's services and employees. DHFS will continue to provide appropriate translated program brochures and forms for distribution.

5. *CMO to Comply with DHFS Guidelines*

The CMO agrees to comply with DHFS's guidelines in the Civil Rights Compliance (CRC) Standards and the Resource Manual for Equal Opportunity in Service Delivery and Employment for a Department of Health and Family Services, its Service Providers and their Subcontractors (October 1997 Edition).

6. *Subcontract Providers*

Requirements herein stated apply to any subcontracts or contracts. The CMO has primary responsibility to take constructive steps, as per the CRC Standards and Resource Manual, to ensure the compliance of its subcontractors. However, where DHFS has a direct contract with another subcontractor, the CMO need not obtain a Subcontractor Civil Rights Compliance Action Plan or monitor that subcontractor.

7. *DHFS Monitoring*

DHFS will monitor the Civil Rights Compliance of the CMO. DHFS will conduct reviews to ensure that the CMO is ensuring compliance by its subcontractors according to guidelines in the CRC Standards and Resource Manual. The CMO agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the CMO, as well as interviews with staff, clients, applicants for services, subcontractors, and referral agencies. The reviews will be conducted according to Department procedures. DHFS will also conduct reviews to address immediate concerns of complainants.

8. *Corrective Action Plan*

The CMO agrees to cooperate with DHFS in developing, implementing and monitoring corrective action plans that result from complaint investigations or monitoring efforts.

9. *CMO Responsibilities*

The CMO agrees that it will:

- a. Hire staff with special translation or sign language skills and/or provide staff with special translation or sign language skills training, or find qualified persons who are available within a reasonable period of time and who can communicate with limited- or non-English speaking or speech- or hearing-impaired clients at no cost to the client;
- b. Provide aids, assistive devices and other reasonable accommodations to the client during the application process, in the receipt of services, and in the processing of complaint or appeals;
- c. Train staff in human relations techniques, sensitivity to persons with disabilities and sensitivity to cultural characteristics;

- d. Make programs and facilities accessible, as appropriate, through outstations, authorized agents or employees, adjusted work hours, ramps, doorways, elevators, or ground floor rooms, and Braille, large print or taped information for the visually or cognitively impaired; and,
- e. Post and/or make available informational materials in languages and formats appropriate to the needs of the target populations.

E. Ineligible Organizations

Upon obtaining information or receiving information from DHFS or from another verifiable source, the CMO shall exclude from participation in the CMO all organizations which could be included in any of the following categories (references to the Act in this section refer to the Social Security Act):

1. *Ineligibility*

Entities which could be excluded under Section 1128(b)(8) of the Social Security Act are entities in which a person who is an officer, director, agent or managing employee of the entity, or a person who has a direct or indirect ownership or control interest of 5% or more in the entity, or a person with beneficial ownership or control interest of 5% or more in the entity has:

- a. Been convicted of the following crimes:
 - i. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under Medicare or Medicaid (see Section 1128(a)(1) of the Act);
 - ii. Patient abuse, i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care (see Section 1128(a)(2) of the Act);
 - iii. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by Federal, State or local government (see Section 1128(b)(1) of the Act);
 - iv. Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal offense described directly above (see Section 1128(b)(2) of the Act); or,
 - v. Offenses relating to controlled substances, i.e., conviction of a State or Federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (see Section 1128(b)(3) of the Act).

- b. Been Excluded from Participation in Medicare or a State Health Care Program. A State health care program means a Medicaid program or any State program receiving funds under title V or title XX of the Act. (See Section 1128(b)(8)(iii) of the Act.)
 - c. Been Assessed a Civil Monetary Penalty under Section 1128A of the Act. Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHHS Office of Inspector General. Section 1128A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards. (See Section 1128(b)(8)(B)(ii) of the Act.)
2. *Contractual Relations*
- Entities which have a direct or indirect substantial contractual relationship with an individual or entity listed above in subsection (a). A substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services:
- a. The administration, management, or provision of medical or long-term care services;
 - b. The establishment of policies pertaining to the administration, management, or provision of medical or long-term care services; or,
 - c. The provision of operational support for the administration, management, or provision of medical or long-term care services.
3. *Excluded Medical Assistance Entities*
- Entities which employ, contract with, or contract through any individual or entity that is excluded from participation in Medicaid under Section 1128 or 1128A of the Act, for the provision (directly or indirectly) of Health Care, Utilization Review, Medical Social Work or Administrative Services. For the services listed, the CMO shall exclude from contracting with any entity which employs, contracts with, or contracts through an entity which has been excluded from participation in Medicaid by the Secretary under the authority of Section 1128 or 1128A of the Act.

The CMO attests by signing this contract that it excludes from participation in the CMO all organizations which could be included in any of the above categories.

F. Compliance with Applicable Law

The CMO shall observe and comply with all Federal and State law in effect when this contract is signed or which may come into effect during the term of this contract, which in any manner affects the CMO's performance under this contract, except as specified in Article III.A, *Provision of Services in the LTC Benefit Package* (page 14).

G. Clinical Laboratory Improvement Amendments

When coordinating laboratory services, the CMO shall use only laboratories that have a valid Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate along with a CLIA identification number and that comply with the CLIA regulations as specified by 42 CFR Part 493, "Laboratory Requirements." Those laboratories with certificates will provide only the types of tests permitted under the terms of 42 CFR Part 493.

H. Annual Audit

1. Requirement to Have an Audit

The CMO shall submit an annual audit, including "Letters to Management", by June 1 of the year following this contract.

2. Audit Requirements

The audit shall be an audit in accordance with the Government Auditing Standards issued by the United States General Accounting Office of the Year-end Financial Statement prepared by the CMO on an accrual accounting basis. Audit must include testing of compliance with program and financial requirements identified in audit guidelines prepared by DHFS. If the CMO is governed by a single county, the audit of the CMO may be a part of the county's annual audit.

The per member per month payments made by DHFS to the CMO are not defined as Federal financial assistance for purposes of determining whether the audit needs to be in accordance with OMB Circular A-133.

3. Submitting the Reporting Package

Two copies of the audit report shall be sent to DHFS at the following address:

DHFS - Office of Program Review and Audit
P.O. Box 7850
Madison, WI 53707-7850
Telephone: (608) 266-2924

4. Access to Auditor's Workpapers

When contracting with an audit firm, the CMO shall authorize its auditor to provide access to work papers, reports, and other materials generated during the audit to the appropriate representatives of DHFS. Such access shall include the right to obtain photocopies of the workpapers and computer disks, or other electronic media, upon which records/working papers are stored.

5. Access to Agency Premises and Records

The CMO shall allow duly authorized agents or representatives of DHFS or the Federal government, during normal business hours, access to the CMO's premises (or to any subcontractor's premises) to inspect, audit, monitor or otherwise evaluate the performance of the CMO's or subcontractor's contractual activities and shall within a reasonable time, but not more than 10 business days, produce all records requested as

part of such review or audit. In the event right of access is requested under this provision, the CMO or subcontractor shall, upon request, provide and make available staff to assist in the audit, evaluation, or inspection effort, and provide adequate space on the premises to reasonably accommodate DHFS or Federal personnel conducting the audit, evaluation, or inspection effort. All inspections, evaluations, or audits shall be conducted in a manner as will not unduly interfere with the performance of CMO's or subcontractor's activities.

6. *Failure to Comply with the Requirements of this Section*

In the event that the CMO fails to have an appropriate audit performed or fails to provide a complete audit report to DHFS within the specified timeframes, in addition to applying one or more of the remedies available under this contract, DHFS may:

- a. Conduct an audit or arrange for an independent audit of the CMO and charge the cost of completing the audit to the CMO; and/or,
- b. Charge the CMO for all loss of Federal or State aid or for penalties assessed to DHFS because the CMO did not submit a complete audit report within the required timeframe.

I. Access to Premises and Information

1. *Access to Premises*

The CMO shall allow duly authorized agents or representatives of the State or Federal government, during normal business hours, access to the CMO's premises or the CMO subcontractors' premises to inspect, audit, monitor or otherwise evaluate the performance of the CMO's or subcontractors' contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this section, the CMO or subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. DHFS may perform off-site audits or inspections to ensure that the CMO is in compliance with contract requirements.

All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of the CMO's or subcontractor's activities. The CMO shall be given 15 business days to respond to any findings of an audit before DHFS shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

2. *Access to and Audit of Contract Records*

Throughout the duration of this contract, and for a period of five years after termination of this contract, the CMO shall provide duly authorized agents of the State or Federal government access to all records and material relating to the contract's provision of and reimbursement for activities contemplated under this contract. Such access shall include the right to inspect, audit and reproduce all such

records and material and to verify reports furnished in compliance with the provisions of this contract. All information so obtained will be accorded confidential treatment as provided under applicable law.

3. *State Contracted Independent Advocacy Entity*

The CMO shall comply with DHFS's direction in regard to the work of the State contracted independent advocacy entity for Family Care.

VIII. Functions and Duties of DHFS

In consideration of the functions and duties of the CMO contained in this contract:

A. State Long-Term Care Council

DHFS shall have a State Long-Term Care Council which consists of 15 members. The council shall perform the following duties at a minimum:

1. *Policy Development*

Assist DHFS in developing broad policy issues related to long-term care services.

2. *Service Department*

Assist DHFS in developing, implementing, coordinating and guiding long-term care services and systems, including making nonbinding recommendations to Department regarding: a) Department standard contract provisions for Resource Centers and CMOs, b) the Family Care benefit, including the per member per month rate structure, c) the community options program, d) the community integration programs, and e) provision of services in the Medicaid fee-for-service system.

3. *Monitor and Review*

Monitor and review: a) pattern of complaints and grievances related to long-term care in order to identify statewide issues, b) number of people on waiting lists, c) pattern of service utilization by CMOs, and d) pattern of CMO enrollment and disenrollments throughout the State.

4. *Annual Report*

Annually report to the legislature and the governor on the status, achievements, problems of Resource Centers and CMOs including: a) number of people served, b) costs of long-term care provided under Family Care, c) number and services areas of Resource Centers and CMOs, d) waiting lists information, and e) results of reviews of quality of services provided by Resource Centers and CMOs.

5. *Staff Training*

Ensure continual training is coordinated by DHFS and offered to CMOs.

6. *Best Practices*

Ensure forums are created for the sharing of best practice among CMOs.

7. *CMO Quarterly Report*

Review quarterly reports on the CMOs' activities and make recommendations for continually improving operations and services to the membership.

B. Center for Delivery Systems Development

The Office of Strategic Finance Center for Delivery Systems Development (CDSD) is the primary point of contact between DHFS, the CMO and other portions of DHFS and DHFS's contract agencies charged with responsibility for administration and implementation of Family Care. CDSD shall assist the CMO in identifying system barriers to implementation of Family Care and shall facilitate intra- and interagency communications and work groups necessary to accomplish full implementation.

C. Reports from the CMOs

DHFS shall have systems in place to ensure that reports and data required to be submitted by the CMO shall be reviewed and analyzed by DHFS in a timely manner. DHFS shall respond accordingly to any indications that the CMO is not making progress toward meeting all performance expectations (e.g., providing timely and accurate feedback to the CMO, and offering technical assistance to help the CMO correct any operational problems).

D. Enrollment

DHFS shall notify the CMO two times per month of all members enrolled in the CMO under this contract. Notification shall be effected through CMO Enrollment Reports. All members listed as an ADD or CONTINUE on either the Initial or Final CMO Enrollment Reports are members of the CMO during the enrollment month. The reports shall be generated in the sequence specified under the CMO Enrollment Reports. The CMO shall review the Enrollment Reports upon receipt and report inaccuracies to DHFS in a timely manner. These reports shall be in both tape and hard copy formats and shall include Medical Status Codes.

E. Forward ID Cards

For those members eligible for Medical Assistance DHFS will issue new members a Family Care Forward card which will provide indication of the member's enrollment in the specific CMO. This card will be issued after enrollment. The card will be a plastic magnetic stripe identification card.

F. Disenrollment

DHFS will promptly notify the CMO of all members no longer eligible to receive services through the CMO under this contract. Notification shall be effected through the CMO Enrollment Reports which DHFS will transmit to the CMO for each month of coverage throughout the term of the contract. The reports shall be generated in the sequence under the CMO Enrollment Reports. Any member who was enrolled in the CMO in the previous enrollment month, but does not appear as an ADD or CONTINUE on either the Initial or Final CMO Enrollment Report for the current enrollment month, is disenrolled from the CMO effective the last day of the previous enrollment month. See Article III.A(6), *Payments for Services* (page 17), regarding conditions for members who continue to have a valid Family Care ID card.

G. Enrollment Reports

For each month of coverage throughout the term of this contract, DHFS shall transmit CMO Enrollment Reports to the CMO. These reports will provide the CMO with ongoing information about its members and disenrollees and will be used as the basis for the monthly per member per month claims described in Article IX.E, *Payment Schedule* (page 90). Enrollment Reports will be generated in the following sequence:

1. Initial Report

The Initial CMO Enrollment Report will list all of the CMO's members and disenrollees for the current enrollment month who are known on the date of report generation. The Initial CMO Enrollment Report will be received by the CMO on or before the fifth day of each month covered by the contract. Each member listed as an ADD or CONTINUE on this report will be listed on the payment report. Members who appear as PEND/CLOSE on the Initial Report and are reinstated into the CMO during the month will appear as an ADD or CONTINUE on the Final Report.

2. Final Report

The final CMO Enrollment Report will list all of the CMO's members for the enrollment month, who were not included in the Initial CMO Enrollment Report. The Final CMO Enrollment Report will be received by the CMO on or before the fifteenth day of each month subsequent to the coverage month. Each member listed as an ADD or CONTINUE on this report will be listed on the payment report. Members in PEND/CLOSE status will not be included on the final report.

H. Utilization Review and Control

DHFS will waive, to the extent allowed by law, any present Department requirements for prior authorization, second opinions, co-payment, or other Medicaid restrictions for the provision of services in the LTC benefit package provided by the CMO to members.

I. Right to Review

DHFS will submit to the CMO for prior approval materials that describe the CMO and that will be distributed by DHFS or County to potential members and members.

J. Review of Study or Audit Results

DHFS shall submit to the CMO for a 15 business day review/comment period, any studies or audits that are going to be released to the public that are about the CMO and Medicaid.

K. Technical Assistance

DHFS shall review reports and data submitted by the CMO and shall share results of this review with the CMO. In conjunction with the CMO DHFS shall determine whether technical assistance may be available to assist in improving performance in any areas of identified need. DHFS, in consultation with the CMO shall develop a technical assistance plan and schedule to assure compliance with all terms of this contract and quality service to members of the CMO.

L. Remedies for Violation, Breach, or Non-Performance of Contract

1. *Basis for Imposition of Sanctions - Service Delivery*

DHFS may impose sanctions as set forth in subsection (2) below only if the CMO acts or fails to act as follows:

- a. Fails substantially to provide necessary services that the CMO is required to provide, under law or under the terms of this contract, to a member covered under this contract, or fails substantially to meet quality standards and performance criteria of this contract such that members are at substantial risk of harm.
- b. Imposes on any member premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program and this contract.
- c. Acts to discriminate among members on the basis of their health status or requirements for services. This includes termination of enrollment or refusal to reenroll a member, except as permitted under the Medicaid program and this contract, or any practice that would reasonably be expected to discourage enrollment by recipients whose condition or history indicates probable need for substantial future services.
- d. Misrepresents or falsifies information that it furnishes to the Department or CMS or to a member, potential member, or a provider.
- e. Distributes directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or contain false or materially misleading information.

2. *Types of Sanctions - Service Delivery*

DHFS may impose sanctions as set forth below for action or a failure to act as set forth in subsection (1) above.

a. *Suspension of New Enrollment*

Whenever the CMO has acted or failed to act in accordance with subsection (1)(a-e) above, DHFS may suspend the CMO's right to receive new enrollment under this contract. DHFS, when exercising this option, must notify the CMO in writing of its intent to suspend new enrollment at least 30 calendar days prior to the beginning of the suspension period. The suspension will take effect if the action or failure to act remains uncorrected at the end of this period. DHFS may suspend new enrollment sooner than the time period specified in this paragraph or appoint Temporary Management as described below if DHFS finds that member long-term care, health or welfare is jeopardized or if the CMO is unable to comply with Federal or State law. The suspension period may be for any length of time specified by DHFS, or may be indefinite. The suspension period may extend up to the expiration of the contract as provided under Article XVI, *CMO Specific Contract Terms* (page 104).

b. *Department-Initiated Enrollment Reductions*

DHFS may reduce the maximum enrollment level and/or number of current members whenever the CMO has failed to provide one or more of the services necessary to achieve outcomes in the LTC benefit package required under Article III.A, *Provision of Services in the LTC Benefit Package* (page 14), or that the CMO has failed to maintain or make available any records or reports required under this contract which DHFS needs to determine whether the CMO is providing the services as required under Article III.A. (Page 14).

The CMO shall be given at least 30 calendar days to correct the lack of necessary services prior to DHFS taking any action set forth in this paragraph. DHFS may reduce enrollment or appoint Temporary Management as set forth below sooner than the time period specified in this paragraph if DHFS finds that member long-term care, health or welfare is jeopardized or if the CMO is unable to comply with Federal or State law.

c. *Withholding of Per Member Per Month Payments and Orders to Provide Services*

Notwithstanding the provisions of Article IX, *Payment to CMO* (page 90), with written notice to the CMO describing such grounds and absent the CMO's prompt and reasonable efforts to remove the grounds described, DHFS may withhold portions of per member per month payments as liquidated damages or otherwise recover damages from the CMO on the following grounds:

- i. Whenever the CMO has failed to provide one or more of the services necessary to achieve outcomes in the LTC benefit package, required under III.A, *Provision of Services in the LTC Benefit Package* (page 14) the Department may either order the CMO to provide such service, or withhold a portion of the CMO's per member per month payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services.
- ii. When the Department withholds payments under this section, the Department must submit to the CMO a list of the members for whom payments are being withheld, the nature of the service(s) denied, and payments the Department must make to provide the services necessary to achieve outcomes.
- iii. If the Department acts under this section and subsequently determines that the services in question were not covered services:
 - In the event the Department withheld payments, it shall restore to the CMO the full per member per month payment; or,
 - In the event the Department ordered the CMO to provide services under this section; it shall pay the CMO the actual documented cost of providing the services.

d. *Contract Termination*

If a basis for imposition of a sanction exists under subsection (1) above, the CMO may be subject to sanctions set forth above or to contract termination under Article XI, *Termination, Modification and Renewal of Contract* (page 97), or DHFS refusal to contract with the CMO in a future time period, as determined by DHFS. The Department will select among these sanctions based upon the nature of the services in question, whether the failure or denial was an isolated instance or a repeated pattern or practice, and whether the long-term care or health of a member was injured, threatened or jeopardized by the failure or denial. This applies not only to cases where the Department has ordered payment after appeal, but also to cases where no appeal has been made (i.e., the Department is knowledgeable about the documented abuse from other sources).

3. *Basis for Imposition of Sanctions - Administration*

DHFS may impose sanctions as set forth in this subsection only if the CMO has acted or failed to act in accordance with the terms of this subsection, DHFS has informed the CMO of the problem and given the CMO a reasonable timeframe and a definite deadline by which to correct the problem on its own and offered and/or provided technical assistance and made recommendations to the CMO on how to correct the problem, and the problem persists either because the CMO refuses to accept technical assistance or fails to make reasonable efforts to implement the recommendations.

- a. If the CMO fails to submit required data and/or information to DHFS or to its authorized agents, or fails to submit such data or information in the required form or format, by the deadline provided for in this subsection, DHFS may impose liquidated damages in the amount of \$100 per day for each day beyond deadline that the CMO fails to submit the data or fails to submit the data in the required form or format, such liquidated damages to be deducted from the CMO's per member per month payments.
- b. Whenever the CMO has failed to perform an administrative function required under this contract, the Department may withhold a portion of future per member per month payments. For the purposes of this section, "administrative function" is defined as any contract obligation other than the actual provision of contract services. The amount withheld by the Department under this section will be an amount that the Department determines in the reasonable exercise of its discretion to approximate the cost to the Department to perform the function. The Department may increase these amounts by 50% for each subsequent non-compliance.
- c. Whenever the CMO has failed to perform the administrative functions defined in Article IX.F, *Third Party Liability (TPL)* (page 90), the Department may withhold a portion of future per member per month payments sufficient to directly compensate the Department for the Medicaid program's costs of providing services and items to members insured by said insurers and/or the insurers/employers represented by said third party administrators.

4. *Notice of Sanctions*

Before imposing any sanction specified in this Article, the Department must give the CMO 30 calendar days written notice that explains the basis and nature of the sanction. If the Department determines conditions for Appointment of Temporary Management, the Department may not delay the imposition of temporary management during the time required for notice procedures as set forth in this section, and may not provide any hearing prior to imposition of temporary management

5. *Notice to CMS*

The Department must notify CMS no later than 30 calendar days after the imposition or lifting of any sanction, said notice to include name of the CMO, the kind of sanction and the reason for the State's decision to impose or lift the sanction.

6. *Appointment of Temporary Management*

- a. The Department has the option to appoint temporary management of the CMO under the following circumstances:
 - i. The CMO repeatedly fails to meet the requirements of this contract; and one of the following exists:
 - ii. There is substantial risk to the health of the CMO's members; or,
 - iii. There is a need to assure the health of the CMO's members during an orderly termination or reorganization of the CMO or improvements are being made to correct violations of this contract.
- b. Temporary management will not be removed until the Department determines the CMO has the capability to ensure the violations will not recur.

7. *Contract Termination*

The Department may terminate this contract as specified in Article XI, *Termination, Modification and Renewal of Contract* (page 97).

8. *Authority of the Secretary*

Section 1903(m)(5)(B)(ii) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny Medicaid payments to a CMO for members who enroll after the date on which the CMO has been found to have committed one of the violations identified in the Federal law. State payments for members of the CMO are automatically denied whenever, and for so long as, Federal payment for such members has been denied as a result of the commission of such violations.

9. *Authority of the Department*

The Department may pursue all sanctions and remedial actions with the CMO that are taken with Medicaid fee-for-service providers. In any case under this contract where

DHFS has the authority to withhold per member per month payments, DHFS also has the authority to use all other legal processes for the recovery of damages.

IX. Payment to CMO

A. Per Member Per Month Payment Rates

In full consideration of services in the LTC benefit package rendered by the CMO, DHFS agrees to pay the CMO monthly payments based on the per member per month payment rate specified in Addendum VI, *Actuarial Basis* (page 132). The per member per month payment rate shall be prospectively designed to be less than the cost of providing the same services covered under this contract to a comparable Medicaid population on a fee-for-service basis. The per member per month payment rate shall not include any amount for recoupment of losses incurred by the CMO under previous contracts.

B. Actuarial Basis

The per member per month payment rate is calculated on an actuarial basis (specified in Addendum VI, *Actuarial Basis* (page 132) recognizing the payment limits set forth in 42 CFR 438.6(c).

C. Renegotiation

The monthly per member per month payment rates set forth in this Article shall not be subject to renegotiation during the contract term or retroactively after the contract term, unless such renegotiation is required by changes in Federal or State law.

D. Reinsurance

The CMO may obtain a risk-sharing arrangement from an insurer other than DHFS for coverage of members under this contract, provided that the CMO remains substantially at risk for providing services under this contract.

E. Payment Schedule

Payment to the CMO shall be based on CMO Enrollment Reports which DHFS will transmit to the CMO. The CMO shall accept payments under this contract as payment in full and shall not bill, charge, collect or receive any other form of payment from DHFS and the member except as permitted by Medicaid regulations as specified in Article III.A(8), *Billing Members* (page 18).

F. Third Party Liability (TPL)

The CMO shall actively pursue, collect and retain any monies from third party payers for services in the LTC benefit package to members except where the amount of reimbursement the CMO can reasonably expect to receive is less than the estimated cost of recovery. Records shall be maintained of all third party collections and reports shall be made quarterly on the form designated by the State in Addendum V, *TPL Report Format* (page 130). The CMO shall be able to demonstrate that appropriate collection efforts were made and followed up on. The CMO shall seek from members information on TPL.

TPL may include, but is not limited to, all other State or Federal medical care programs which are primary to Medicaid, group or individual health insurance and casualty collections.

Casualty collections means any recoverable amounts arising out of settlement of torts or Worker's Compensation. State subrogation rights have been extended to the CMO under s. 49 Wis. Stats., including s. 49.89.

Where the CMO has entered a risk-sharing arrangement with DHFS, the collection and distribution of third party liabilities shall follow the procedures described in Addendum III, *Capacity for Financial Solvency* (page 122).

Collections from third party payers are the responsibility of the CMO or its subcontractors. The CMO and subcontractors shall not pursue collection from the member but directly from the third party payer.

G. Recoupments

DHFS will not normally recoup per member per month payments made to the CMO when the CMO actually provided service or the person is subsequently determined ineligible. However, DHFS may recoup per member per month payments made to the CMO in the following situations:

1. Change of Eligibility Status

DHFS will recoup per member per month payments made to the CMO when a member's status has changed because:

- a. The member voluntarily disenrolls;
- b. The member fails to meet functional or financial eligibility and the member has exhausted his/her grievances processes including a fair hearing which the member has requested;
- c. The member initiates a move out of the CMO service area;
- d. The member fails to pay, or to make satisfactory arrangements to pay, any cost share amount due the CMO after a 30 calendar day grace period;
- e. The member dies; or,
- f. The member is ineligible for Medical Assistance as an Institutionalized Individual consistent with 42CFR435.1008 and as defined in 42CFR435.1009.

No recoupment under this section will occur unless the CMO knew or should have known of such status change.

2. *Disputed Membership*

When membership is disputed, DHFS shall be the final arbitrator of membership and reserves the right to recoup an inappropriate per member per month payment.

3. *Contract Termination*

If this contract is terminated, recoupments will be accomplished through a payment by the CMO within 30 calendar days of contract termination.

X. Reports and Data

A. Management Information System

1. *MIS Requirements*

The CMO shall meet all of the reporting requirements as specified in this contract in a timely way, assure the accuracy and completeness of the data, and submit the reports/data in a timely manner. Data submitted to DHFS shall be supported by records available for inspection or audit by DHFS. The CMO must be able to submit data and/or reports to DHFS, or receive data and/or reports from DHFS in a secure format. The CMO shall designate a contact person responsible for the computer/data reporting who is available to answer questions from DHFS and resolve any issues regarding reporting requirements. The CMO's Management Information System (MIS) shall be sufficient to support quality assurance/quality improvement requirements described in Article VI, *CMO Functions: Quality Assurance/Quality Improvement* (page 63).

2. *Claims Processing*

The CMO shall have a claims processing system which meets the specifications of Article V.C(3), *Thirty Day Payment Requirement*, and (4), *Claims Retrieval System* (page 58).

3. *HSRS Reports*

For reporting periods during the year 2002, the CMO shall report member-specific data on the HSRS Long-Term Support Module as directed by DHFS. CMO staff will participate in the planning and development of data reporting requirements for implementation of data reporting requirements during the term of this contract consistent with all HIPAA requirements applicable to the CMO. This participation will include attending workgroup meetings, addressing necessary changes to local databases, and cooperating with DHFS on data submission protocol and testing.

Prior to the effective date of this contract for the year 2003, the CMO shall demonstrate it has the MIS capacity to:

- a. Analyze, integrate and report data;
- b. Capture and maintain a member level record of all services in the LTC benefit package, and provided to members by the CMO and its providers, in a

computerized data base adequate to meet the reporting requirements of the contract;

- c. Monitor enrollment and disenrollment, in order to determine which members are enrolled or have disenrolled from the CMO on any specific day;
 - d. Collect and accurately produce data, reports, and member histories including, but not limited to, member and provider characteristics, encounter data, utilization, disenrollments, solvency, appeals and grievances which satisfies the reporting requirements identified under B, *Reports: Regular Interval*, and C, *Reports: As Needed* of this Article; and,
 - e. Ensure that data received from providers, and reported to DHFS, is timely, accurate and complete, by:
 - i. Verifying the accuracy and timeliness of reported data;
 - ii. Screening the data for completeness, logic, and consistency;
 - iii. Collecting information on services in standardized formats, such as the HCFA 1500 or UB92 format, or other uniform format, to the extent possible;
 - iv. Recording and tracking all services with a unique member identification number (the Medicaid ID number shall be recorded for all members who are Medicaid recipients).
4. *Encounter Data Format*
- Beginning on a date to be determined by mutual agreement of the parties and consistent with any HIPAA deadlines applicable to the CMO, the CMO shall report member-specific data to DHFS in an encounter-data format specified by DHFS. Prior to the implementation of reporting in the encounter data format, the CMO shall meet certification standards that demonstrate it has the MIS capacity to meet DHFS reporting requirements in the formats and timelines prescribed by DHFS. The CMO will provide data extracts, as necessary, for testing the reporting processes and will assist with and participate in the testing processes.

B. Reports: Regular Interval

The CMO agrees to furnish information from its records to DHFS, and to DHFS's authorized agents, which DHFS may require to administer this contract. See Addendum IV, *Reporting* (page 127), for a compilation of these and other reports/documents and due which are specified in this contract. The reports with a regular interval include, but not limited to the following:

1. *Third Party Liability (TPL) Report*

Summaries of amounts recovered from third parties for services rendered to members under this contract in the format specified in Addendum V, *TPL Report Format* (page 130). TPL Reports are due 30 calendar days after the end of each quarter.

2. *Client Specific Data Report*

The Client Specific Data Report is a monthly report. The report is due 30 calendar days after the reporting period. The Client Specific Data Report contains the following components:

- a. Reporting on the Long-Term Support Module of HSRS which has been modified for CMO's reporting. It will be used to report member specific enrollment and disenrollment, utilization of services and expenditure in the LTC benefit package, and member characteristic/demographics. The HSRS reporting shall be reported on-line or through a batch methodology approved by DHFS.
- b. Other client specific data required by DHFS. The reporting shall be reported by a methodology approved by DHFS.

3. *Financial Report*

- a. The Financial Report is due 45 calendar days after the reporting period. The initial reporting period shall begin on January 1 of the current contract year and end on the last day of February of the current contract year. All subsequent reporting periods shall be one calendar month for each remaining month of this contract or any extension of this contract. The monthly Financial Report contains the following components:
 - i. A balance sheet showing CMO assets, liabilities and equity on the last day of the month being reported and for the most recent December 31.
 - ii. An income statement showing CMO revenue, expenses and net income for the month and year being reported compared to budget.

Each report must be prepared on an accrual basis and in accordance with Generally Accepted Accounting Principles. In addition, each statement must provide sufficient detail to allow a determination on the part of State analysts with regard to the CMOs financial position. Monthly financial report templates will be provided to the CMO, however the CMO may elect to report using their own format so long as all required information is provided and DHFS approved of the alternate report form.

- b. A year-end financial report is due on or before May 31. The purpose of the year-end financial report is to provide State analysts with CMO management's analysis of the financial condition of the CMO, both in absolute terms and in comparison to prior reporting periods. At a minimum, the following topics must be addressed in the year-end financial report:

- i. Financial position of the CMO, through submission of updated financial reports through the end of the calendar year;
- ii. Results of operations;
- iii. CMO cash flow and liquidity position;
- iv. Compliance with statutory/contract requirements; and,
- v. Justification of year-end IBNR and allowance for doubtful accounts figures as adjusted, and an explanation of how they were calculated. This should include the IBNR model and a schedule of claims paid by month in the current year for the reporting calendar year. (Ex. Jan, Feb, Mar & Apr claims payment dates for dates of service of the reporting period, “the run-out”)
- vi. Explanation of material budget vs. actual variances.

4. *Narrative Report*

The quarterly Narrative Report is due 30 calendar days after the reporting period. DHFS review of the Narrative Report must be completed within 60 calendar days of receipt and notice sent to the CMO of any necessary follow-up and information to be included in the next report. DHFS may from time to time revise elements to be included in the Narrative Report and shall give the CMO notice of new elements to include in the Report prior to the commencement of the next reporting period. The Quarterly Narrative Report contains the following components:

- a. Summary of key accomplishments, significant challengers or barriers encountered and solutions found, and major goals for next quarter
- b. Marketing activities
- c. Consumer participation
- d. Critical incidents aggregate data
- e. Stories

5. *Performance Improvement Project Executive Summary Reports*

The specifics of this report are detailed in Addendum IX, *Performance Improvement Projects* (page 139).

6. *Complaint and Grievance Report*

The specifics of this report are detailed in Article IV.L(3), *Documentation and Reporting*, (page 46).

7. *Civil Rights Compliance Report*

The specifics of this report are detailed in Article VII.D, *Civil Rights* (page 77).

8. *Annual Audit*

The specifics of this audit are in Article VII.H, *Annual Audit* (page 81).

9. *Business Plan*

The specifics of this plan are detailed in Article VII.A(2), *Business Plan* (page 73).

10. *CMO Quality Indicators*

The specifics regarding this data and timeframes are in Addendum II, *CMO Quality Indicators* (page 114).

C. Reports: As Needed

The CMO agrees to furnish reports to DHFS, and to DHFS's authorized agents, which DHFS may require to administer this contract, that are specific to certain events. Such reports include but not limited to the following:

1. *Personal Injury Settlements*

When the CMO is aware of personal injury case settlements, the CMO shall submit any information regarding such settlement to DHFS as soon as practical. The CMO shall use the form attached in Addendum VII, *Medicaid CMO Personal Injury Settlements* (page 134), for reporting these settlements.

2. *Reporting of Corporate and Other Changes*

If corporate restructuring or any other change affects the continuing accuracy of certain information previously reported by the CMO to DHFS, the CMO shall report the change in information to DHFS. The CMO shall report each such change in information as soon as possible, but not later than 30 calendar days after the effective date of the change. Changes in information covered under this section include all of the following:

a. Any change in information relevant to Article VII.E, *Ineligible Organizations* (page 79).

b. Any change in information relevant to V.B(12)(c), *Potential Sources of Disclosure Information* (page 55).

D. Disclosure

The CMO and any subcontractors shall make available to DHFS, DHFS's authorized agents, and appropriate representatives of the U.S. Department of Health and Human Services any financial records of the CMO or subcontractors which relate to the CMO's capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this contract. The CMO shall comply with applicable record-keeping requirements specified in HFS 105.02(1)-(7) Wis. Adm. Code, as amended.

E. Records Retention

The CMO shall retain, preserve and make available upon request all records relating to the performance of its obligations under this contract, including claim forms, for a period of not less than five years from the date of termination of this contract. Records involving matters which are the subject of litigation shall be retained for a period of not less than five years following the termination of litigation. Electronic copies of the documents contemplated herein may be substituted for the originals with the prior written consent of DHFS, provided that the electronic storage format is approved by DHFS as reliable and is supported by an effective retrieval system.

Upon expiration of the five-year retention period, the CMO may request authority from DHFS to destroy, dispose of or transfer the records identified directly above. The CMO shall retain such records until it receives written approval from DHFS.

XI. Termination, Modification and Renewal of Contract

A. Modification

This contract may be modified at any time by written mutual consent of the CMO and DHFS or when modifications are mandated by changes in Federal or State laws, and amendments to Wisconsin's CMS approved waivers: #0154.90.R1; #0229.90.04; #0297.02; and #0275.90. In the event that changes in State or Federal law require DHFS to modify its contract with the CMO, notice shall be made to the CMO in writing. However, the per member per month payment rate to the CMO can be modified only as provided in Article IX.C, *Renegotiation* (page 90).

If DHFS exercises the right to renew this contract, DHFS will recalculate the per member per month payment rate for succeeding calendar years. The CMO shall have 60 calendar days to accept the new per member per month payment rate in writing or to initiate termination of the contract. If DHFS changes the reporting requirements during the term of this contract, the CMO shall have 30 calendar days to review and comment on the fiscal impact of the additional reporting requirements. DHFS will consider any potential fiscal impact on the CMO before requiring additional reporting. It is not DHFS's intent to unilaterally impose new and previously unreimbursed requirements on the CMO. The CMO shall have 180 calendar days to comply with such changed requirements or to initiate termination of the contract.

B. Mutual Consent of Termination

This contract may be terminated at any time by mutual written consent of both the CMO and DHFS.

C. Unilateral Termination

This contract between the parties may be unilaterally terminated only as follows:

1. Notice of Termination

This contract may be terminated by either party for any reason upon 90 calendar days written notice to the other party.

2. *Changes in Federal or State Law*

This contract may be terminated at any time, by either party, due to modifications mandated by changes in Federal or State law, regulations, or policies that materially affect either party's rights or responsibilities under this contract. In such case, the party initiating such termination procedures must notify the other party in writing, at least 90 calendar days prior to the proposed date of termination, of its intent to terminate this contract. Termination by DHFS under these circumstances shall impose an obligation upon DHFS to pay the CMO's reasonable and necessarily incurred termination expenses.

3. *Termination for Substantial Failure to Perform*

This contract may be terminated by either party at any time if it determines that the other party has substantially failed to perform any of its functions or duties under this contract. In such event, the party exercising this option must notify the other party, in writing, of this intent to terminate this contract and give the other party 30 calendar days to correct the identified violation, breach or non-performance of contract. If such violation, breach or non-performance of contract is not satisfactorily addressed within this time period, the exercising party must notify the other party, in writing, of its intent to terminate this contract at least 90 calendar days prior to the proposed termination date. The termination date shall always be the last day of a month. The contract may be terminated by DHFS sooner than the time period specified in this paragraph if DHFS finds that member long-term care, health or welfare is jeopardized by continued enrollment in the CMO. A "substantially failed to perform" for purposes of this paragraph includes any violation of any requirement of this contract that is repeated or on-going, that goes to the essentials or purpose of the contract, or that injures, jeopardizes or threatens the long-term care, health, safety, welfare, rights or other interests of members, the CMO's failure to meet or maintain at least minimal certification or contract requirements or to make substantial progress in meeting enrollment goals in the CMO's approved enrollment plan. A violation is considered repeated and ongoing if the CMO fails to demonstrate improvement or comply with technical assistance recommendations of DHFS.

4. *Termination When Federal or State Funds Unavailable*

This contract may be terminated by either party, in the event Federal or State funding of contractual services rendered by the CMO become or will become permanently unavailable. In the event it becomes evident State or Federal funding of claims payments or contractual services rendered by the CMO will be temporarily suspended or unavailable, DHFS shall immediately notify the CMO, in writing, identifying the basis for the anticipated unavailability or suspension of funding. Upon such notice, DHFS or the CMO may suspend performance of any or all of the CMO's obligations under this contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. DHFS or CMO shall attempt to give notice of suspension of performance of any or all of the CMO's obligations by 60 calendar days prior to said suspension, if this is possible; otherwise, such notice of suspension should be made as soon as possible. In the event funding temporarily suspended or unavailable is reinstated, the CMO may remove suspension hereunder

by written notice to DHFS, to be made within 30 calendar days from the date the funds are reinstated. In the event the CMO elects not to reinstate services, the CMO shall give DHFS written notice of its reasons for such decision, to be made within 30 calendar days from the date the funds are reinstated. The CMO shall make such decision in good faith and will provide to DHFS documentation supporting its decision. In the event of termination under this section, this contract shall terminate without termination costs to either party.

D. Contract Non-Renewal

The CMO or DHFS may decide to not renew this contract. In the case of a non-renewal of this contract the party deciding to not renew this contract must notify the other party in writing at least 90 calendar days prior to the expiration date of this contract, and following the procedure in E and F in this Article.

E. Transition Plan

In the case of this contract being terminated or a decision to not renew this contract, the CMO shall submit a written plan, that receives DHFS's approval, to ensure uninterrupted delivery of services to CMO members and their successful transition to applicable programs (e.g. Medicaid fee-for-service, Community Options Program, Community Integration Program). The plan will include provisions for the transfer of all member related information held by the CMO or its providers and not also held by DHFS.

1. Submission of the Transition Plan

The CMO shall submit the plan at one of the following times, depending on which applies: no less than 90 calendar days prior to the contract's expiration when the CMO decides to not renew the contract; within 10 business days of notice of termination by DHFS; or along with the CMO's notice of termination.

2. Management of the Transition

The CMO shall designate a person responsible for coordinating the transition plan and will assign staff as DHFS determines is necessary to assist in the transition. Status meetings including staff from all parties involved in the transition will be held as frequently as DHFS determines is necessary.

3. Continuation of Services

If the CMO has been unable to successfully transition all members to applicable programs by the time specified in the approved transition plan, the CMO shall continue operating as a CMO under this contract until all members are successfully transitioned. DHFS will determine when all members have been successfully transitioned to applicable programs.

If DHFS determines it necessary to do so, the CMO will agree to extend this contract, in order to continue providing services to members until they are successfully transitioned to applicable programs. During this period the CMO remains responsible, and shall provide, the services in the LTC benefit package, and all terms and conditions of the contract will apply during this period.

F. Obligations of Contracting Parties

When termination or non-renewal of this contract occurs, the following obligations shall be met by the parties:

1. *Notice to Members*

DHFS shall be responsible for developing the format for notifying all members of the date of termination and process by which the members continue to receive services in the LTC benefit package;

2. *CMO Responsibilities*

The CMO shall be responsible for duplication, mailing and postage expenses related to said notification;

3. *Return of Advanced Payments*

Any payments advanced to the CMO for coverage of members for periods after the date of termination or expiration shall be returned to DHFS within 45 calendar days;

4. *Transfer of Information*

The CMO shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims; and,

5. *Recoupments*

Recoupments will be handled through a payment by the CMO within 90 calendar days of the end of this contract.

XII. Cooperation of Parties and Dispute Resolution

A. Agreement to Cooperate

The parties agree to fully cooperate with each other in connection with the performance of their respective obligations and covenants under this contract.

B. Dispute Resolution

The parties shall use their best efforts to cooperatively resolve disputes and problems that arise in connection with this contract. When a dispute arises between the CMO and the DHFS that cannot be resolved, the method of resolving the dispute shall be the follow process:

1. *Disputes Involving Audits*

For any audit dispute, review will be through the DHFS audit resolution process.

2. *Disputes Involving All Other Matters*

For any other dispute, The CMO may request a hearing under ch. 227, Wis. Stats. with the Division of Hearings and Appeals, Department of Administration, under rules promulgated at HA 1, Wis. Adm. Code. The proceeding will be conducted as a class 3 contested case.

C. Performance of Contract Terms During Dispute

The existence of a dispute notwithstanding, both parties agree to continue without delay to carry out all their respective responsibilities which are not affected by the dispute and the CMO further agrees to abide by the interpretation of DHFS regarding the matter in dispute while the CMO seeks further review of that interpretation.

XIII. Confidentiality of Records

The CMO agrees that all information, records, and data collected in connection with this contract shall be protected from unauthorized disclosure as provided in Ch. 46Wis. Stats., HFS 108.01, Wis. Admin. Code, and 42 CFR 431 Subpart F. Except as otherwise required by law, access to such information shall be limited by the CMO and DHFS to persons who, or agencies which, require the information in order to perform their duties related to this contract, including the U.S. Department of Health and Human Services and such others as may be required by DHFS.

The CMO shall have written confidentiality policies and procedures in regard to confidential member information. Policies and procedures must be communicated to the CMO staff, members, and providers. The transfer of member records to non-CMO providers or other agencies not affiliated with the CMO are contingent upon the receipt by the CMO of written authorization to release such records signed by the member or by the member's authorized representative.

XIV. Documents Constituting Contract

This contract is drafted in accordance with the requirements of Wisconsin Statutes sections 46.2805 to 46.2895 and Chapter HFS10 of the Wisconsin Administrative Code. The contract between the CMO and DHFS shall include, in addition to this contract and applicable provisions of the state statutes and administrative code and the CMO Contract Interpretation Bulletins issued pursuant to this contract. Each Contract Interpretation Bulletin shall be provided to the CMO for review and comment at least 30 calendar days prior to its effective date. In the event of any conflict in provisions among these documents, the laws and regulations of the state and federal government shall prevail. In addition, the contract shall incorporate the following Addenda:

- I. Definitions;
- II. CMO Quality Indicators;
- III. Capacity for Financial Solvency and Stability;
- IV. Reporting;
- V. Third Party Liability (TPL) Report Format;
- VI. Actuarial Basis;
- VII. Medicaid CMO Personal Injury Settlements;
- VIII. Critical Incidents Protocol;
- IX. Performance Improvement Projects;

The documents listed above constitute the entire contract between the CMO and DHFS and no other expression, whether oral or written, constitutes any part of this contract.

XV. Miscellaneous

A. Delegations of Authority

No delegations of authority are permitted under this contract without prior approval by DHFS.

B. Indemnification

1. CMO and DHFS Liability

The CMO will indemnify, defend if requested and hold harmless the State and all of its officers, agents and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the operations of the CMO or any of its contractors, in prosecuting work under this contract. DHFS acknowledges that the State may be required by Wis. Stat. Section 895.46(1) to pay the cost of judgments against its officers, agents or employee, and that an officer, agent or employee of the State may incur liability due to negligence or misconduct.

2. Pass along Federal Penalties

- a. The CMO shall indemnify DHFS for any federal fiscal sanction taken against DHFS or any other state agency which is attributable to action or inaction by the CMO, its officers, employees, agents or subcontractors that is contrary to the provisions of this Contract.
- b. Prior to invoking this provision, DHFS agrees to pursue any reasonable defense against the federal fiscal sanction in the available federal administrative forum. The CMO shall cooperate in that defense to the extent requested by DHFS.
- c. Upon notice of a threatened federal fiscal sanction, DHFS may withhold payments otherwise due to the CMO to the extent necessary to protect DHFS against potential federal fiscal sanction. DHFS will consider the CMO's requests regarding the timing and amount of any withholding adjustments.

C. Independent Capacity of the CMO

DHFS and the CMO agree that the CMO and any agents or employees of the CMO, in the performance of this contract, shall act in an independent capacity, and not as officers or employees of DHFS.

D. Omissions

In the event that the CMO or DHFS hereto discovers any material omission in the provisions of this contract which such party believes is essential to the successful performance of this contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to

perform the objectives of this contract, or shall pursue the arbitration process available under Article XII, *Cooperation of Parties and Dispute Resolution* (page 100).

E. Choice of Law

This contract shall be governed by and construed in accordance with the laws of the State of Wisconsin. The CMO shall be required to bring all legal proceedings against DHFS in the State courts in Dane County, Wisconsin.

F. Waiver

No delay or failure by the CMO or DHFS hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

G. Severability

If any provision of this contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to members and if the remainder of this contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

H. Force Majeure

The CMO and DHFS shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

I. Headings

The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

J. Assignability

Except as allowed under subcontracting, this contract is not assignable by the CMO either in whole or in part, without the prior written consent of DHFS.

K. Right to Publish

DHFS agrees to allow the CMO to write and have such writings published provided the CMO receives prior written approval from DHFS before publishing writings on subjects associated with the work under this contract. The CMO agrees to protect the privacy of individual members, as required under 42 CFR Part 434.6(a)(8).

XVI. CMO Specific Contract Terms

County(ies) in which enrollment is accepted: «County»

Per Member Per Month Payment Rate

The prospective payment rate shall be determined in accordance with the calculations set forth in Addendum VI, *Actuarial Basis* (page 132).

Monthly per member per month payment rate for each member at the intermediate level of care: \$657.40. Monthly per member per month payment rate for each member at the comprehensive level of care: «Comprehensive_».

Monthly per member per month payment rate for each member eligible only as a “grandfather”: For members who are functionally eligible through the grandfathering provision, and not functionally eligible at the comprehensive or intermediate level of care, the CMO will be paid the actual cost of the care plan services, except for case management services, during the 60 calendar days before the Family Care benefit became available in the CMO county. The CMO shall receive an additional \$50.00 per month for case management for each grandfathered enrollee. The total will be paid to the CMO on a prospective basis. (See the definition of “eligibility” in addendum I, *Definitions*, beginning page 105, regarding the grandfathering provision). Persons eligible for Family Care under this grandfather provision are entitled to all the benefits and rights of membership in the CMO and all contract provisions apply equally to them.

THIS CONTRACT SHALL BECOME EFFECTIVE ON JANUARY 1, 2003, AND SHALL EXPIRE ON DECEMBER 31, 2003, UNLESS TERMINATED EARLIER.

In WITNESS WHEREOF, the State of Wisconsin and «County» County have executed this contract:

FOR CMO:

FOR STATE:

BY: «Signature», «Title»
«Department»
«County» County

BY: Charles Wilhelm, Director
Office of Strategic Finance
Dept. of Health & Family Services

DATE

DATE

Addenda

I. Definitions

- (1) “Abuse” means any of the following, if done intentionally, negligently or recklessly:
 - a) An act, omission or course of conduct by another that is not reasonably necessary for treatment or maintenance of order and discipline and that does at least one of the following:
 - Results in bodily harm or great bodily harm to an enrollee.
 - Intimidates, humiliates, threatens, frightens or otherwise harasses an enrollee.
 - b) The forcible administration of medication or treatment with the knowledge that no lawful authority exists for the administration or performance.
- (2) “Activities of daily living” or “ADLs” means bathing, dressing, eating, mobility, transferring from one surface to another such as bed to chair and using the toilet.
- (3) “Adult family home” or “AFH” has the meaning specified in s. 50.01 (1), Stats.
- (4) “Adult protective services” means protective services for mentally retarded and other developmentally disabled persons, for aged infirm persons, for chronically mentally ill persons and for persons with other like incapacities incurred at any age as defined in s. 55.02, Stats.
- (5) Advance Directive—a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated.
- (6) “Assets” means any interest in real or personal property that can be used for support and maintenance. “Assets” includes motor vehicles, cash on hand, amounts in checking and savings accounts, certificates of deposit, money market accounts, marketable securities, other financial instruments and cash value of life insurance.
- (7) “Assistance” means cueing, supervision or partial or complete hands-on assistance from another person.
- (8) “At risk of losing independence or functional capacity” means having the conditions or needs described in s. HFS 10.33 (4) (b).

- (9) “Care management organization” or “CMO” means an entity that is certified as meeting the requirements for a care management organization under s. 46.284 (3), Stats., and this chapter and that has a contract under s. 46.284 (2), Stats., and s. HFS 10.42. “Care management organization” does not include an entity that contracts with DHFS to operate a PACE or Wisconsin partnership program.
- (10) “Case Management” means assessment, care planning, assistance in arranging and coordinating services in the care plan, assistance in filing complaints and grievances and obtaining advocacy services, and periodic reassessment and updates of the person’s care plan.
- (11) Cash Reserve—a segregated fund account that the CMO establishes to ensure continuity of care for its members, accountability to taxpayers, solvency protection against financially catastrophic cases, and effective program administration.
- (12) Center for Medicare and Medicaid Services (CMS)—The Federal agency, formerly known as “Health Care Finance Administration” (HCFA), responsible for oversight and federal administration of Medicare and Medicaid programs.
- (13) “Client” means a person applying for eligibility for the Family Care benefit, an eligible person or an enrollee.
- (14) “Client Rights” means rights in Family Care outlined in applicant information materials and the member handbook as approved by DHFS consistent with HFS 10.51.
- (15) “Community-based residential facility” or “CBRF” has the meaning specified in s. 50.01 (1g), Stats. Except that utilization of CBRFs in Family Care shall comply with the following:
 - a) There are no bed size limits for elderly and people with physical disabilities who enroll in a Family Care CMO.
 - b) CBRF bed size limits will be in effect for all people with a developmental disability who enroll in a Family Care CMO. CMOs may serve members who are developmentally disabled in a CBRF with more than 4 beds only if the CBRF is licensed for more than 4 but not more than 8 beds and a variance has been requested and approved by DHFS (variance requests for the use of facilities between 5-8 beds should be sent to the Community Integration Specialist and the Area Administrator contact for the appropriate DHFS region); or the person resided in and received services funded by COP, Community Aids or other funding, in a CBRF larger than 8 beds prior to enrolling in the CMO and has made informed choice to remain. This must be documented as follows:

- The CMO shall produce a list and maintain a list of all persons with a developmental disability who, on the effective date of the CMOs first HCS Contract resided and received services funded by county COP or Community Aids in CBRFs larger than 8 beds, and
 - The interdisciplinary team records in the member's individual service plan that during the first year after enrollment the member has been shown and offered the option of at least one smaller CBRF (8 beds or less), but has chosen not to relocate.
- (16) "Community spouse" means an individual who is legally married as recognized under state law to a Family Care spouse.
- (17) "Complaint" means any communication made to DHFS, a resource center, a care management organization or a service provider by or on behalf of a client expressing dissatisfaction with any aspect of the operations, activities or behaviors of DHFS, resource center, care management organization or service provider related to access to or delivery of the Family Care benefit, regardless of whether the communication requests any remedial action.
- (18) Contract/This Contract/Health and Community Supports Contract—this contractual agreement between DHFS of Health and Family Services and the CMO and its addenda, which is a Pre-Paid Health Plan (PHP).
- (19) "Countable assets" means assets that are used in calculating financial eligibility and cost sharing requirements for the Family Care benefit.
- (20) "County agency" means a county department of aging, social services or human services, an aging and disability resource center, a Family Care district or a tribal agency, that has been designated by DHFS to determine financial eligibility and cost sharing requirements for the Family Care benefit.
- (21) "Crime" means conduct which is prohibited by state law and punishable by fine or imprisonment or both. Conduct punishable only by a forfeiture is not a crime.
- (22) "Critical Incident" means an event, incident, or course of action or inaction that is either "unexpected" or that is the result of alleged "abuse", "neglect", or other "crime", or a violation of "client rights, and that results in:
- a) Harm to health, safety and well being of an enrollee or another person, or
 - b) Substantial loss in the value of the personal or real property of an enrollee or another person.
- (23) Days—unless otherwise specified in the contract (e.g., "calendar days"), days shall mean business days.

- (24) “Developmental disability” means a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, that has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. “Developmental disability” does not include senility that is primarily caused by the process of aging or the infirmities of aging.
- (25) “DHFS” means the Wisconsin Department of Health and Family Services.
- (26) Eligibility/Eligible Person—A person is eligible for membership in the CMO if the person meets all eligibility requirements as determined by the Resource Center and Economic Support Unit prior to Enrollment in the CMO or upon recertification of eligibility by the Resource Center and Economic Support Unit.
- (27) “Enrollee” means a person who is enrolled in a care management organization to receive the Family Care benefit.
- (28) “Fair hearing” means a de novo proceeding under ch. HA 3 before an impartial administrative law judge in which the petitioner or the petitioner’s representative presents the reasons why an action or inaction by DHFS, a county agency, a resource center or a CMO in the petitioner’s case should be corrected.
- (29) “Family Care benefit” has the meaning given in s. 46.2805 (4), Stats., namely, financial assistance for long-term care and support items for an enrollee.
- (30) “Family Care district” means a special purpose district created under s. 46.2895 (1), Stats.
- (31) “Family Care spouse” means an individual who is a Family Care applicant or enrollee and is legally married as recognized under state law to an individual who does not reside in a medical institution or a nursing facility.
- (32) “Financial eligibility and cost-sharing screen” means a uniform screening tool prescribed by DHFS that is used to determine financial eligibility and cost-sharing under s. 46.286 (1) (b) and (2), Stats., and ss. HFS 10.32 and 10.34.
- (33) “Functional capacity” means the skill to perform activities in an acceptable manner.
- (34) “Functional screen” means a uniform screening tool prescribed by DHFS that is used to determine functional eligibility under s. 46.286 (1) (a) and (1m), Stats., and ss. HFS 10.32 and 10.33.
- (35) “Home” means a place of abode and lands used or operated in connection with the place of abode.
- (36) “Hospital” has the meaning specified in s. 50.33 (2), Stats.

- (37) Ineligibility/Ineligible Person—a person is ineligible for membership in the CMO if the person fails to meet all eligibility requirements as determined by the Resource Center or Economic support Unit prior to Enrollment in the CMO, or if the person determined to be eligible prior to enrollment no longer meets eligibility requirements as determined by the Resource Center or Economic Support Unit
- (38) “Infirmities of aging” has the meaning given in s. 55.01 (3), Stats., namely organic brain damage caused by advanced age or other physical degeneration in connection therewith to the extent that the person so afflicted is substantially impaired in his or her ability to adequately provide for his or her care or custody.
- (39) “Instrumental activities of daily living” or “IADLs” means management of medications and treatments, meal preparation and nutrition, money management, using the telephone, arranging and using transportation and the ability to function at a job site.
- (40) Long-Term Care Benefit Package/LTC Benefit Package—services provided by the CMO directly or through other providers for which DHFS makes a per member per month payment to the CMO.
- (41) “Local long-term care council” means a council appointed under s. 46.282 (2), Stats.
- (42) “Long-term care facility” means a nursing home, adult family home, community-based residential facility or residential care apartment complex.
- (43) Marketing/Outreach Activities—the production and dissemination of marketing/outreach materials and the sponsorship of community events that can be reasonably interpreted as intended to influence individuals to enroll or reenroll in the CMO.
- (44) Marketing/Outreach Materials—materials in all mediums, including but not limited to, internet, brochures and leaflets, newspaper, magazine, radio, television, billboards, yellow pages, advertisements, other print media and presentation materials, used by or on behalf of the CMO to communicate with individuals who are not members, and that can be reasonably interpreted as intended to influence the individuals to enroll or reenroll in the CMO.
- (45) Medicaid, the Wisconsin Medical Assistance program operated by the Wisconsin Department of Health and Family Services under Title XIX of the Federal Social Security Act, Ch. 49, Wis. Stats., and related State and Federal rules and regulations. The term “Medicaid” will be used consistently in the contract. However, “Medicaid” is also known as “MA,” “Medical Assistance,” and “WMAF.”

(46) “Medical institution” means a facility that meets all of the following conditions:

- a) Is organized to provide medical care, including nursing and convalescent care.
- b) Has the necessary professional personnel, equipment and facilities to manage the medical, nursing and other health care needs of patients on a continuing basis in accordance with accepted professional standards.
- c) Is authorized under state law to provide medical care.
- d) Is staffed by professional personnel who are responsible for professional medical and nursing services. The professional medical and nursing services include adequate and continual medical care and supervision by a physician, registered nurse or licensed practical nurse supervision and services and nurses’ aide services sufficient to meet nursing care needs and a physician’s guidance on the professional aspects of operating the institution.

(47) Medically Necessary Services—are Medicaid services (as defined under s. 49.46 Wis. Stats. and ch. Wis Admin. Code 107) that are required to prevent, identify or treat a member’s illness, injury or disability; and that meet the following standards:

- a) Is consistent with the member’s symptoms or with prevention, diagnoses or treatment of the member’s illness, injury or disability;
- b) Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
- c) Is appropriate with regard to generally accepted standards of medical practice;
- d) Is not medically contraindicated with regard to the member’s diagnoses, symptom, or other medically necessary services being provided to the member;
- e) Is of proven medical value or usefulness and, consistent with s. HSS 107.035, is not experimental in nature;
- f) Is not duplicative with respect to other services being provided to the member;
- g) Is not solely for the convenience of the member, the member’s family or a provider;
- h) With respect to prior authorization of a service and other prospective coverage determinations made by DHFS, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the member; and,
- i) Is the most appropriate supply or level of service that can safely and effectively be provided to the member.

- (48) Member—a person who meets the eligibility criteria and has signed an Enrollment Request.
- (49) Necessary Long-Term Care Services and Supports—include any service or support that is provided to assist a member complete daily living activities, learn new skills, maintain a general sense of safety and well-being, or otherwise pursue a normal daily life rhythm, and that meets the following standards:
 - a) Is consistent with the member’s comprehensive assessment and Individual Service Plan;
 - b) Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
 - c) Is appropriate with regard to Department’s and CMO’s generally accepted standards of long-term care and support;
 - d) Is not duplicative with respect to other services being provided to the member;
 - e) With respect to prior authorization of a service and other prospective coverage determinations made by the CMO, is cost-effective compared to an alternative necessary long-term care service which is reasonably accessible to the member; and,
 - f) Is the most appropriate supply or level of service that can safely and effectively be provided to the member.
- (50) “Neglect” means an act, omission or course of conduct by another that, because of the failure to provide adequate food, shelter, clothing, medical care or dental care, creates a significant danger to the physical or mental health of an enrollee.
- (51) “Nursing home” has the meaning specified in s. 50.01 (3), Stats.
- (52) “Older person” means a person who is at least 65 years of age.
- (53) “PACE” means a program of all-inclusive care for the elderly authorized under 42 USC 1395 to 1395gg.
- (54) “Physical abuse” means the willful or reckless infliction of bodily harm. Bodily harm means physical pain or injury, illness, or any impairment of physical condition.

- (55) “Physical disability” means a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, that results from injury, disease or congenital disorder and that significantly interferes with or significantly limits at least one major life activity of a person. In the context of physical disability, “major life activity” means self-care, performance of manual tasks unrelated to gainful employment, walking, receptive and expressive language, breathing, working, participating in educational programs, mobility other than walking and capacity for independent living.
- (56) “Private pay individual” means any of the following:
- a) A person who is a member of a CMO’s target population and who does not qualify financially for the Family Care benefit under s. HFS 10.34.
 - b) (b) A person who is eligible for the Family Care benefit under s. HFS 10.32, but who is not entitled to receive the benefit immediately as specified in s. HFS 10.36 (3).
 - c) (c) A person who meets the entitlement conditions specified in s. HFS 10.36 (1), but who is waiting for enrollment in a CMO under the phase-in provisions of s. HFS 10.36 (2).
- (57) Recipient—any individual entitled to benefits under Title XIX of the Social Security Act, and under the Medicaid State Plan as defined in Chapter 49, Wis. Stats.
- (58) “Residential care apartment complex” or “RCAC” has the meaning specified in s. 50.01 (1d), Stats.
- (59) “Resource center” or “aging and disability resource center” means an entity that meets the standards for operation and is under contract with DHFS to provide services under s. 46.283 (3), Stats., and this chapter or, if under contract to provide a portion of the services specified under s. 46.283 (3), Stats., meets the standards for operation with respect to those services.
- (60) “Respite care” means temporary placement in a long-term care facility for maintenance of care, treatment or services, as established by the person’s primary care provider, in addition to room and board, for no more than 28 consecutive calendar days at a time.
- (61) Risk— the result of the CMO’s agreement with DHFS to provide the membership with a range of services for a fixed sum per member per month payment. The CMO assumes a degree of financial risk to provide services within the set dollar amount.
- (62) Risk Sharing Mechanism—the terms under which DHFS and the CMO shall share in the CMO’s operating losses as described in Addendum II, CMO Quality Indicators (page 114).

- (63) “Secretary” means the secretary of DHFS.
- (64) Service Area— the geographic area within which potential members must reside in order to enroll and remain enrolled in the CMO under this contract. Potential members shall be residents of the county (or one of the counties) listed in Article XVI, CMO Specific Contract Terms, page 104.
- (65) Services Necessary to Achieve Outcomes—services necessary to achieve outcomes identified in the member’s Individual Service Plan include both “necessary long-term care services” and “medically necessary services.” The CMO can offer reasonable alternative services that meet a member’s needs and desired outcomes at less expense. Reasonable alternatives are those which:
 - a) Have been effective for persons with similar needs; and,
 - b) Would not have significant negative impact on desired outcomes.
- (66) “Sexual abuse” means sexual conduct in the first through fourth degrees as defined in s. 940.225 Wis. Stats.
- (67) Subcontract—any written agreement between the CMO and another party for services in the LTC benefit package, and other products and services provided to the CMO.
- (68) Subcontractor/CMO Provider—a service provider the CMO has an agreement with for providing services to CMO’s members. “Applicant” means a person who directly or through a representative makes application for the Family Care benefit.
- (69) “Unexpected” means an event or incident that occurs without warning, and was not anticipated or considered probable.
- (70) “Target population” means any of the following groups that a resource center or a care management organization has contracted with DHFS to serve:
 - a) Older persons.
 - b) Persons with a physical disability.
 - c) Persons with a developmental disability.

II. CMO Quality Indicators

This addendum lists the quality indicators the CMO will report directly to the Department. These indicators will help highlight areas for improvement in service delivery and program management by the CMOs. Results from the first year of reporting will be used to help set standards and benchmarks, where appropriate, and to analyze the validity of this data as quality indicators. Since Family Care is a pilot project, the Department has not yet defined the minimum standard(s) CMOs need to reach, and has not yet finalized the set of indicators that will be used to measure quality. As stated elsewhere, the CMO is responsible for making sure member outcomes are achieved.

The purpose of including these indicators in the contract is to communicate to the CMO specific areas the Department will be monitoring, and indicate which areas the CMO will need to collect information for the Department.

Focus Area	Self Determination & Rights
Consumer Outcome	<ul style="list-style-type: none"> People choose their services. People choose their daily routine.
Quality Indicator	Percent of members choosing some level of self-directed supports. (Risk adjustment issues should be considered with this indicator.)
Population Groupings	Stratify by target population and age.
Performance Measure	<u>Numerator</u> : Number of members with any SPC that has a 'D' in Long-Term Support Code Field 26. <u>Denominator</u> : Total number of members enrolled.
Data Source	HSRS
Data Elements	Client demographics, program eligibility date, SPC code.
Timeframe	Contract period. Point in time measurement.
Reporting Requirements	CMO: Timely and accurate data entry into HSRS information, i.e., closing conventional supports, SPC 'C' in Long-Term Support Code Field 26 and opening self-directed supports, SPC 'D' in Long-Term Support Code Field 26 according to members' involvement in self-directed support.

Focus Area	Self Determination & Rights
Consumer Outcome	<ul style="list-style-type: none"> People have privacy.
Quality Indicator	Percent of members who live in a CBRF or an AFH and who reside in a private room.
Population Groupings	Stratify by target population and provider type (CBRF or AFH).

Performance Measure	<p><u>Numerator 1</u>: Number of members living in AFHs who have private rooms.</p> <p><u>Denominator 1</u>: Total number of members living in AFHs.</p> <p><u>Numerator 2</u>: Number of members living in CBRFs who have private rooms.</p> <p><u>Denominator 2</u>: Total number of members living in CBRFs.</p>
Data Source	CMO data.
Data Elements	Client demographics, SPC code, CMO information regarding single or shared room.
Timeframe	Contract period. Point in time measurement.

Focus Area	Self Determination & Rights
Consumer Outcome	<ul style="list-style-type: none"> People achieve their employment objectives.
Quality Indicator	<p>Percent of members whose current and principal employment setting is sheltered workshop, prevocational work sites, or supported employment settings.</p> <p>Percent of members who want to work and are working (and are not working.)</p> <p>Percent of members receiving vocational supports who find and maintain employment in integrated settings and earn increased wages.</p>
Population Groupings	Stratify by target population and age according to the following age ranges: 17.5-21yrs, 22-39yrs, 40-59yrs, 60-74yrs, 75+yrs.
Performance Measure	<p><u>Numerator</u>: Number of members who are employed by category – SPC 108-10 (prevocational sites), SPC 108-20 (sheltered workshop sites), and 615 (supported employment). (This numerator does not count members who are independently employed without supports).</p> <p><u>Denominator</u>: Total members who are working (this number is obtained from the LTC Functional Screen).</p> <p>And</p> <p><u>Numerator</u>: Two ratios: Number of members who are employed independently, number of total members who are employed (independently and with supports.)</p> <p><u>Denominator</u>: Total members in Family Care.</p>
Data Source	<ul style="list-style-type: none"> HSRS LTC Functional Screen
Data Elements	Client demographics, program eligibility date, SPC code.
Timeframe	Contract period. Point in time measurement.

Reporting Requirements	<p>CMO: Timely, accurate and complete data entry into HSRS, i.e., SPC Codes 108-10, 108-20 or 615 for members who are employed and receive support in one or more settings related to those Codes.</p> <p>CMO: Timely and accurate completion of LTC Functional Screen (most recent version) for members who's annual re-certification re-screening is being completed by the CMO.</p>
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Focus Area	Self Determination & Rights
Consumer Outcome	<ul style="list-style-type: none"> People choose their services.
Quality Indicator	<ol style="list-style-type: none"> Percent of direct service providers¹ who have one or more consumers on their governing boards or advisory committees. Percent of direct service providers who have one or more family members on their governing boards or advisory committees.
Population Groupings	Direct service provider type (delineated by population served).
Performance Measure	<p><u>Numerator 1</u>: All direct service providers that are subcontracted by the CMO who report that they have one or more consumers on their governing boards or advisory committees.</p> <p><u>Numerator 2</u>: All direct service providers that are subcontracted by the CMO who report that they have one or more family members on their governing boards or advisory committees.</p> <p><u>Denominator</u>: All direct service providers that are subcontracted by the CMO.</p>
Data Source	<ul style="list-style-type: none"> Provider survey
Data Elements	Client demographics, program eligibility date, SPC code for supportive home care worker.
Timeframe	Contract period 2002-2003.
Reporting Requirements	CMO: Provide indicator data report in fourth quarter narrative report to DHFS.

Focus Area	Community Integration & Social Roles
Consumer Outcome	<ul style="list-style-type: none"> People choose where and with whom to live.
Quality Indicator	Percent of members who move into the community from an institutional setting.
Population Groupings	Stratify by target population, gender, ADL and age according to the following age ranges: 17.5-21yrs, 22-39yrs, 40-59yrs, 60-74yrs, 75+yrs.

¹ Direct service providers are defined as the following provider types that serve more than 10 people: 102 Adult day care, 103 Residential respite, 104 Supportive Home Care, 105 Home Health, 108 Prevocational services, 110 Daily living skills training, 202 Adult family home, 203 Children's Foster Home, 505 Nursing Home, 505 ICF-MR or State DD Center, 506 CBRF, 507 Counseling and Therapeutic, 615 Supported employment, 704 Day treatment – medical, 705 Detoxification - social setting, 706 Day center services treatment, 710 Skilled nursing services

Performance Measure	<p><u>Numerator 1</u>: Number of members whose prior location was a general nursing home, ICF/MR, or brain injury rehab unit (field 13, N, F, & B).</p> <p><u>Denominator 2</u>: Total number of members enrolled.</p> <p><u>Numerator 2</u>: Same as above.</p> <p><u>Denominator 2</u>: Total number of members residing in an institution.</p>
Data Source	HSRS, Functional Screen Data.
Data Elements	Client demographics, gender, program eligibility date, HSRS field 13.
Timeframe	Contract period.
Reporting Requirements	<p>CMO: Timely, accurate and complete data entry into HSRS, i.e., Field 13 Code N, F or B according to members' location.</p> <p>CMO: Timely and accurate completion of LTC Functional Screen of members at time of re-certification for those CMOs completing annual re-certification re-screening of members.</p>

Focus Area	Community Integration & Social Roles
Consumer Outcome	<ul style="list-style-type: none"> • People choose where and with whom they live. • People participate in the life of the community.
Quality Indicator	<p>Current member living arrangement.</p> <ul style="list-style-type: none"> a) Percent living in unregulated community settings (e.g., Own home or apartment; Supervised Community Living); b) Percent living in regulated community settings (e.g., AFHs, CBRFs, RCACs) categorized by size of setting as listed below); c) Percent living in institutional settings (e.g., ICF/MR, Center for Persons with Developmental Disabilities, nursing facility); d) Percent of members who have no permanent address. e) Number of people living where they prefer to live and number of members living in setting not of their preference.
Population Grouping	<p>Stratify by target population, gender, ADL/IADLs and age according to the following age ranges: 17.5-21yrs, 22-39yrs, 40-59yrs, 60-74yrs, 75+yrs.</p> <p>(In addition to target population and age, this measure may be risk adjusted based on functional status to indicate key differences between people who receive LTC services and reside in certain settings).</p>
Performance Measure	<p><u>Numerator 1</u>: Number of members currently residing in each of the following settings (as reported in HSRS field 11):</p> <ul style="list-style-type: none"> • Own Home or Apartment (30); • Supervised Community Living (60); <p><u>Numerator 2</u>: Number of members currently residing in each of the following settings (as reported in HSRS field 11):</p>

	<ul style="list-style-type: none"> • Adult Family Home, 1-2 beds (37). • Adult Family Home 3-4 beds (38); • CBRF, 5-8 beds (61); • CBRF, 9-15 beds (code to be determined); • CBRF, 16-20 beds (code to be determined); • CBRF, 21-50 beds (code to be determined); • CBRF, 51-99 beds code to be determined); • CBRF, 100 + beds (code to be determined); • CBRF, Independent Apartments (63); • Residential Care Apartment Complex (70). <p><u>Numerator 3</u>: Number of members currently residing in each of the following settings (as reported in HSRS field 11)</p> <ul style="list-style-type: none"> • Developmental Disability Center (32); • ICF/MR (07); • Nursing Home (33); • Brain Injury Unit, Nursing Home (51). <p><u>Numerator 4</u>: Percent of members who have no permanent address (as reported in HSRS field 11 in the following setting):</p> <ul style="list-style-type: none"> • No permanent address or homeless shelter; (code to be determined). <p><u>Denominator</u>: Total members.</p>
Data Source	<ul style="list-style-type: none"> • HSRS • Functional Screen Data
Data Elements	Client demographics, gender, program eligibility date, HSRS field 11.
Reporting Requirements	<p>CMO: Timely, accurate and complete data entry into HSRS, i.e., Field 11.</p> <p>CMO: Timely and accurate completion of Functional Screen of members at time of re-certification for those CMOs completing annual re-certification re-screening of members.</p>

Focus Area	Health & Safety
Consumer Outcome	People experience continuity and security.
Quality Indicator	Percent of social service coordinators and RNs who separated during the reporting period (i.e., turnover rate). Separation is defined as movement out of an organization (i.e., it includes resignations as well as terminations). Separations do not include transfers or promotions within an organization.
Population Grouping	None. (Interdisciplinary team members are reported by provider type, i.e., social service coordinator, registered nurse).

Performance Measure	<p><u>Numerator</u>: Number of interdisciplinary team members in the denominator who separated during the reporting year, i.e., who were not employed by the CMO as of December 31 of the reporting period (the numerator should include all interdisciplinary team members regardless of why they separated, e.g., retired, etc.).</p> <p><u>Denominator</u>: The total number of interdisciplinary team members employed by the CMO as of December 31 of the year preceding the reporting year. Do not count the number of positions, e.g., if three different persons were employed in a particular position during the year, all three would be counted as part of the total number of interdisciplinary team members. There are no exclusions from the denominator, i.e., all providers should be included whether they died, retired, were terminated or relocated during the reporting year.</p>
Data Source	CMO data.
Data Elements	Providers by name and provider type (i.e., SW or RN), effective date of employment, and termination date.
Timeframe	Contract period.
Reporting Elements	CMO: Provide indicator data in fourth quarter narrative report to DHFS.

Focus Area	Health & Safety
Consumer Outcome	People have the best possible health.
Quality Indicator	Percent of CMO members who received an influenza vaccine in the past 12 months and who were members of the CMO at least during the time the influenza vaccine is available.
Population Grouping	Stratified by population, sex and age according to the following age ranges: 17.5-21yrs, 22-39yrs, 40-59yrs, 60-74yrs, 75+yrs.
Performance Measure	<p>Numerator: Number of CMO members in the denominator whose service record contains documentation that an influenza vaccine was administered during the reporting period.</p> <p>Denominator: The number of members continuously enrolled during the time when the influenza vaccine is available (i.e., fall and early winter) and who are not receiving end of life care.</p>
Data Source	CMO service records.
Data Elements	Member name, Medicaid ID #, age, sex and target population.
Timeframe	Contract year 2002-2003.
Reporting Requirements	CMO: Provide indicator data report in fourth quarter narrative report to DHFS.

Focus Area	Health & Safety
Consumer Outcome	People have the best possible health.
Quality Indicator	Percent of CMO members who received a pneumovax vaccine in last ten years.
Population Grouping	Stratified by population, sex and age according to the following age ranges: 17.5-21yrs, 22-39yrs, 40-59yrs, 60-74yrs, 75+yrs.
Performance Measure	Numerator: Number of CMO members in the denominator whose service record contains documentation of having had a pneumovax vaccine. Denominator: The number of members continuously enrolled for at least 6 months during the reporting period.
Data Source	CMO service records
Data Elements	Member name, Medicaid ID #, age, sex and target population.
Timeframe	Contract year 2002-2003.
Reporting Requirements	CMO: Provide indicator data report in fourth quarter narrative report to DHFS.

Focus Area	Health & Safety
Consumer Outcome	<ul style="list-style-type: none"> People have continuity and security.
Quality Indicator	<ol style="list-style-type: none"> Percent change in number of personal care workers in the CMO network during the contract period. Percent change in number of supportive care workers in the CMO network during the contract period.
Population Groupings	Stratify by type of provider (i.e., personal care worker, supportive home care worker).
Performance Measure	<p><u>Numerator #1</u>: Total number of personal care workers in the CMO network as of December 31st of the reporting period.</p> <p><u>Denominator #1</u>: Total number of personal care workers in the CMO network as of December 31st of the previous reporting period.</p> <p>Numerator #2: Total number of supportive home care workers in the CMO network as of December 31st of the reporting period.</p> <p>Denominator #2: Total number of supportive home care workers in the CMO network as of December 31st of the previous reporting period.</p>
Data Source	<ul style="list-style-type: none"> Provider survey
Data Elements	Provider type, provider agency name, date contract effective.
Timeframe	Contract period. Point in time measurement.
Reporting Requirements	CMO: Provide indicator data report in fourth quarter narrative report to DHFS.

Focus Area	Health & Safety
Consumer Outcome	<ul style="list-style-type: none"> People are satisfied with services.
Quality Indicator	Percent of members who voluntarily disenroll and transfer to Medicaid fee-for-service or the COP/waiver program.
Population Groupings	Stratify by target population and age according to the following age ranges: 17.5-21yrs, 22-39yrs, 40-59yrs, 60-74yrs, 75+yrs.
Performance Measure	<p><u>Numerator 1</u>: Number of members who disenroll voluntarily (which is reported in HSRS field 24 – SPC 802, sub-codes 51, 52) and transfer to Medicaid fee-for-service or one of the COP/waiver programs.</p> <p><u>Denominator 1</u>: All members who disenroll in the CMO (i.e. total members with a code in HSRS field 24 – SPC 802 with any disenrollment sub-code).</p> <p><u>Numerator 2</u>: Same as numerator 1.</p> <p><u>Denominator 2</u>: Total CMO enrollment.</p>
Data Source	HSRS
Data Elements	Client demographics (i.e. Client LN, FN, MI, Medicaid number, SSN, client ID, DOB, special project status, and county), program eligibility date, episode end date, CMO disenrollment SPC.
Timeframe	Contract period (however, this indicator will be more meaningful when trended over two or more contract periods). Point in time measurement. (Example of point in time measurement: all members who were enrolled in the CMO as of December 31 of the preceding year who were not enrolled as of December 31 of the reporting year.)
Reporting Requirements	CMO: Provide indicator data report in fourth quarter narrative report to DHFS.

III. Capacity for Financial Solvency and Stability

Prior to the effective date of this contract, the CMO must meet the standards for certification set forth in Administrative Rule at HFS 10.43(4)(a) requiring that the CMO shall demonstrate the capacity for financial solvency and stability and the ability to assume the level of financial risk required under this contract. Components necessary to demonstrate organizational fiscal capacity shall include: adequate working capital as set forth in section A. of this addendum, restricted reserve as set forth in section B. of this addendum and solvency and termination requirements as set forth in section C. of this addendum. For purposes of this addendum capitation payment will mean all payments by DHFS to the CMO to provide services in the LTC Benefit Package to the CMO's members. During the term of this contract the CMO shall establish a separate and distinct fund within the county structure exclusively for operation of the CMO on an accrual basis of accounting.

DHFS will share risk of losses, provided that the CMO will share savings with DHFS. To participate in risk sharing, the CMO shall request, in writing and prior to the effective date of this contract, sharing of losses and savings for the term of this contract. Renewal of risk sharing is only available for a CMO in the second or third calendar year of operation as a CMO. Risk sharing shall be in accordance with section D. of this addendum.

A. Working Capital

1. *Purpose.* The purpose of working capital is to provide ongoing liquid assets to manage routine fluctuations in revenue and expenses that will occur in the day to day normal course of business operations.
2. *Working Capital Calculation and Minimum Balance.* Working capital shall be an amount calculated by the CMO, and agreed to by DHFS, that is the difference between current assets and current liabilities, but shall be maintained at a level not less than 2% of the projected annual capitation payments from DHFS to the CMO for the period of this contract.
3. *Reports.* The CMO shall include working capital as part of the monthly financial reports in a format developed by DHFS or similar format developed by the CMO to provide the same information.
4. *Failure to Maintain Required Minimum Balance.* In the event the CMO fails to maintain and report adequate working capital for three consecutive months, the CMO shall submit a corrective action plan for DHFS approval which shall at a minimum include analysis of the reasons for the shortfall and a plan for restoring an adequate working capital balance. If the CMO continues to maintain inadequate working capital, DHFS may impose any sanctions consistent with Article VIII.L, *Remedies for Violation, Breach, or Non-Performance of Contract*,

(page 86) or terminate the contract in accordance with Article XI.C, *Unilateral Termination* (page 97).

B. Restricted Reserve

1. *Purpose.* The purpose of the restricted reserve is to provide continuity of care for enrolled members, accountability to taxpayers, and effective program administration including the ability to manage the operation of the CMO as a separate and distinct fund with adequate liquid assets to manage volatility of the program.
2. *Restricted Reserve Funds.* The CMO shall establish and maintain a separately identifiable reserve account on the chart of accounts to receive the contributions required under this section. Deposits to and withdrawals from the restricted reserve are to be clearly identifiable within the accounting system and supported by documentation of their compliance with (3) *Required Contributions* and (4) *Disbursements*, directly below.
3. *Required Contributions.* The requirements under this subsection apply during the period of this contract to any CMO.
 - a. *Initial Balance.* Prior to the effective date of this contract, the CMO shall have a minimum balance that is the greater of \$250,000 or 50% of the amount calculated under (d) of this subsection in the restricted reserve fund account.
 - b. *Contribution.* The CMO shall deposit an amount that will provide not less than the minimum balance required under (d) of this subsection, *Required Minimum Balance*.
 - c. *Earnings.* Any income or gains generated by the restricted reserve funds are to remain within the account until the CMO meets the required minimum balance as set forth in subsection (d) *Required Minimum Balance* immediately below.
 - d. *Required Minimum Balance.* The minimum balance is an amount set for the term of each contract which is based on the annual capitation payment as projected by the CMO and concurred in by DHFS. The projection shall be agreed upon between the CMO and DHFS calculated as follows:
 - 8% of the first \$5 million of annual capitation
 - 5% of the next \$5million of annual capitation
 - 3% of the next \$10 million of annual capitation
 - 2% of the next \$30 million of annual capitation
 - 1% of any additional annual capitation to a maximum required minimum balance of \$2 million.

- e. The CMO shall attain required minimum balance on or before December 31, 2003 that is 100% of the amount as calculated using the formula immediately above.
4. *Disbursements.* Once the minimum balance is met or when DHFS allows, disbursements may be made from the restricted reserve account in order to fund payments to DHFS under risk sharing, to fund recoupment if applicable, to fund operating expenses, or for any other purpose approved by DHFS. For any withdrawals or disbursements that are made, the following requirements apply:
 - a. *Disbursement Notifications.* The CMO must first obtain DHFS approval for withdrawals or disbursements, if the withdrawal or disbursement results in a balance below the required minimum balance. DHFS shall approve requests only after consideration of all solvency protections available to the CMO. Withdrawals or disbursements that result in an account balance below the required minimum balance will only be approved for risk sharing, recoupment, working capital or operating expenses of the CMO.
 - b. *Plans for Replenishing Restricted Reserve When Below Minimum.* The CMO shall have a plan, approved by DHFS in its sole discretion, which specifies the methods and timetable the CMO shall employ to replenish the restricted reserve fund if below the minimum balance. Failure to submit an acceptable plan to DHFS may subject the CMO to the remedies specified in Article VIII.L, *Remedies for Violation, Breach, or Non-Performance of Contract* (page 86). In approving or disapproving the plan, DHFS will take into account existing or additional solvency protections available to the CMO.
5. *Reporting.* The CMO shall report on the status of the restricted reserve account as part of the monthly financial report required under this contract.
6. *Failure to Maintain Required Minimum Balance.* In the event the CMO fails to maintain and report adequate restricted reserve, DHFS may impose any sanctions consistent with VIII.L, *Remedies for Violation, Breach, or Non-Performance of Contract* (page 86) or terminate the contract in accordance with Article XI.C, *Unilateral Termination* (page 97).

C. Solvency and Termination Requirements

1. *General Requirements.* On or before the effective date of this contract, the CMO shall provide evidence of solvency protections through means acceptable to DHFS, including without limitation, county guarantee or contribution to an individual solvency fund. Except as agreed upon between the parties, the CMO shall retain solvency protection for the term of this contract consistent with the means acceptable to DHFS on the effective date of this contract. The CMO shall inform DHFS of any change or anticipated change to the solvency protections of the CMO, or any events or occurrences likely to affect the CMO's solvency, as

soon as possible but no later than 10 business days after the CMO becomes aware of such changes, events or occurrences.

2. *Solvency Options.* The CMO shall demonstrate financial solvency and the ability to assume the level of financial risk required under this contract. If the CMO is operated by a county or county agency, the following requirements apply:
 - a. *County Guarantee.* The county guarantees that the county is responsible for all financial obligations of the CMO. The county shall establish a separately identifiable reserve account on the chart of accounts in the amount of \$250,000 for any CMO with projected annual capitation payments in excess of \$10,000,000, restricted for use in the event the CMO becomes insolvent. The insolvency account ensures the availability of immediate liquid assets to assure continuity of care during any time necessary for the county to develop funds necessary to meet all obligations of the CMO; or
 - b. *Individual Pledged Solvency Account.* The CMO shall deposit funds into an account maintained by DHFS, or into a restricted account approved by DHFS until such time as an account maintained by DHFS is established to receive such deposits. DHFS shall hold funds on behalf of the CMO until the CMO terminates operation as a CMO.

The CMO shall have 50% of the required account balance by December 31, 2002. Calculation shall be based upon the projected capitation payments and required account balances as follows:

- 10% of the first \$5 million of annual capitation (minimum balance of not less than \$400,000);
 - 5% of the next \$5 million of annual capitation;
 - 2.5% of the next \$10 million of annual capitation;
 - 1% of any additional capitation to a maximum required balance of \$2 million.
 - No later than November 1, 2002, the CMO shall submit for approval, plans for additional deposits to achieve 100% of the required account balance by December 31, 2003.
3. *Distribution.* Upon termination DHFS shall disburse funds in the pledged insolvency account or funds held by the CMO in accordance with the county guarantee in the following order:
 - To satisfy outstanding expenses of the CMO for services authorized and provided to members of the CMO;
 - To pay for the costs of Temporary Management appointed in accordance with Article VIII.L(6), (page 89);
 - To satisfy outstanding administrative expenses provided under contract with the CMO by a vendor owned and operated by an entity other than the CMO;

- To satisfy outstanding claims by the state or federal government for recoupment or risk sharing;
 - To pay for the costs associated with the transition of members following disenrollment;
 - To pay for internal expenses of the CMO including wages, salaries and other compensation of administrative and program staff; and,
 - To the CMO.
4. *Failure to Maintain Required Minimum Balance.* In the event the CMO fails to maintain and report adequate solvency protection, DHFS may impose any sanctions consistent with VIII.L, *Remedies for Violation, Breach, or Non-Performance of Contract* (page 86) or terminate the contract in accordance with Article XI.C, *Unilateral Termination* (page 97).

IV. Reporting

Before the Effective Date of the Contract. Before the effective date of this contract the following documents or any modifications to these documents must receive approval from DHFS:

1. Member Handbook, as described in Article II.B, *Member Handbook* (page 4).
2. QA/QI Plan, as described in Article VI, *CMO Functions: Quality Assurance/Quality Improvement* (page 63).
3. Subcontracts, as described in Article V.B.(9), *Requirements for Subcontracts* (page 51).
4. Adequate Service Coverage Plan, as described in Article V.B(7), *Before Effective Date of Contract* (page 49).
5. Marketing/Outreach Plan and Materials (if any materials), as described in Article II.A, *Approval of Marketing/Outreach Plans and Materials* (page 2).
6. Prevention and Wellness Plan as described in Article III.E, *Prevention and Wellness* (page 31).
7. Business Plan, which includes monthly budget, revenue and enrollment projections, as described in Article VII.A(2), *Business Plan* (page 73).
8. Internal Appeal and Grievance process as described in Article IV. H, *Department Appeal and Grievance Resolution Process* (page 44).
9. Self Directed Supports Plan as described in Article III.B(2), *Self-Directed Supports* (page 21).
10. Member Safety and Risk Policies, as described in Article III.D, *Member Safety and Risk* (page 30).
11. Service Authorization Policies, as described in Article VI.E, *Authorization of Services and Utilization Management* (page 68).
12. Template notification letter used to inform members of intention to reduce, delay, or terminate a current service, or to deny payment for a service, as described in Article IV.G(3), *Notice of Action* (page 39).

During the Course of This Contract: The following table is provided for information only. Due dates indicated in the table are based upon reporting requirements as set forth in Article X.B.

Report	Reporting Period	Due Date
TPL Quarterly Report	4 th Quarter 2002	January 30, 2003
	1 st Quarter 2003	April 30, 2003
	2 nd Quarter 2003	July 30, 2003
	3 rd Quarter 2003	October 30, 2003
	4 th Quarter 2003	January 30, 2004
Client Specific Data Report	December 2002	January 30, 2003
	January 2003	March 2, 2003
	February 2003	March 30, 2003
	March 2003	April 30, 2003
	April 2003	May 30, 2003
	May 2003	June 30, 2003
	June 2003	July 30, 2003
	July 2003	August 30, 2003
	August 2003	September 30, 2003
	September 2003	October 30, 2003
	October 2003	November 30, 2003
	November 2003	December 30, 2003
	December 2003	January 30, 2004
Monthly Financial Report	November 2002	January 15, 2003
	December 2002	February 15, 2003
	January & February 2003	April 15, 2003
	March 2003	May 15, 2003
	April 2003	June 15, 2003
	May 2003	July 15, 2003
	June 2003	August 15, 2003
	July 2003	September 15, 2003
	August 2003	October 15, 2003
	September 2003	November 15, 2003
	October 2003	December 15, 2003
	November 2003	January 15, 2004
	December 2003	February 15, 2004
Year-End Financial Report	2002 Year-End Report	May 31, 2003
	2003 Year-End Report	May 31, 2004

Narrative Report	4 th Quarter 2002	January 30, 2003
	1 st Quarter 2003	April 30, 2003
	2 nd Quarter 2003	July 30, 2003
	3 rd Quarter 2003	October 30, 2003
	4 th Quarter 2003	January 30, 2004
Performance Improvement Project Report	2002 Executive Summary	March 1, 2003
	2003 Executive Summary	March 1, 2004
Grievance Report & Log	2002 Annual Report & Log	February 1, 2003
	2003 Annual Report & Log	February 1, 2004
Quality Indicators Report	2002 QI Report	January 31, 2003
	2003 QI Report	January 31, 2004

The CMO shall submit all reports according to reporting periods on due dates indicated in this Addendum to DHFS:

Department of Health and Family Services
CDSD-Contracts Section
One South Pinckney Street, Suite 340
P.O. Box 1379
Madison, WI 53701-1379

Prior to Future Contract Renewals. Before the effective date of future Health and Community Supports contracts, the following documents must receive approval from DHFS:

1. Marketing/outreach plan, as described in Article II.A, *Approval of Marketing/Outreach Plans and Materials* (page 2).
2. Updated Member Handbook
3. Certification of Subcontracts, as described in Article V.B(9), *Requirements for Subcontracts* (page 51)
4. Complete Provider Network Listing
5. Enrollment Plan, as described in Article VII.A(2)(a), *Business Plan* (page 73).

V. Third Party Liability (TPL) Report Format

State of Wisconsin Medicaid the CMO Report on Third Party Liability

Name of the CMO: _____

Mailing Address: _____

Office Telephone: _____

Provider Number: _____

Please designate below the quarter period for which information is given in this report.

_____, 19____ through _____, 19_____

INSTRUCTIONS

For the purposes of this report, a member is any individual listed on the monthly enrollment reports coming from EDS.

Casualty recovery may include collections from auto, homeowners, or malpractice insurance, as well as restitution payments from the Division of Corrections, and by uninsured motorists. In addition, casualty recoveries should include collections from Workers' Compensation. Casualty recovery as such is defined as collections resulting from liabilities arising out of any kind of personal injury, whether in tort or Workers' Compensation. Examples of tort claims would include auto accidents, slip and fall, defective products, or medical and legal malpractice.

Birth costs are not a third party right, and consequently are not included in this report.

Third Party Liability (TPL) Reports are to be completed on a calendar quarterly basis.

Please complete and return this report within 30 days of the end of the quarter being reported to:

Department of Health and Family Services
CDSD-Contracts Section
One South Pinckney Street, Suite 340
P.O. Box 1379
Madison, WI 53701-1379

Attn: TPL Report from _____ CMO

Third Party Liability (TPL) Report

Private Health Insurance

1. Dollar Amount Billed_____
2. Dollar Amount Collected or Avoided_____
3. Number of Members Involved_____
4. Total Number of Insured Members_____

Medicare

5. Dollar Amount Billed_____
6. Dollar Amount Collected or Avoided_____
7. Number of Medicare Members_____

Casualty

8. Accounts Receivable, End of Period_____
9. Dollar Amount Recovered or Avoided_____
10. Total Cases Settled_____
11. Total Settlements with Compromise_____
12. Dollar Amount Compromised_____

I HEREBY CERTIFY that to the best of my knowledge and belief, the information contained in this report is a correct and complete statement prepared from the records of the CMO, except as noted in the report.

Signed_____

Original Signature of Director or Administrator

Title_____ Date_____

VI. Actuarial Basis

The per member per month capitation rates for this contract were developed by DHFS in conjunction with Milliman USA, Actuaries and Consultants. This addendum presents a summary of the major steps in the rate setting process. All detail for the calculation of these rates can be found in the document “Family Care Capitation Rates, CY 2003.”

1. The comprehensive rates were a blend of two rating methodologies:
 - a. CY 2001 rates trended forward one additional year, comprising 50% of the final capitation rate;
 - i. Additional detail on the calculation of the CY 2001 rates can be found in the document “Wisconsin Department of Health and Family Services Family Care 2001 Prospective Rate Development.”
 - ii. Additional detail on the development of the new trend factor can be found in the report “Family Care Capitation Rates, CY 2003.”
 - b. Functional status-based rates, comprising 50% of the final capitation rate.
 - i. The functional status-based rate is calculated in seven main steps, with a separate calculation being carried out for each Family Care CMO. These steps are as follows:
 - (1) Identify functional status measures from the Wisconsin Long-Term Care Functional Screen that are predictive of long-term care service costs within the managed care environment;
 - (2) Use statistical techniques to determine the specific dollar impact that each functional status indicator has on long-term care service cost;
 - (3) Establish the October, 2002, casemix across the relevant functional status indicators for each CMO;
 - (4) Weight each of the specific dollar impacts identified in step 2 with the weights established in step 3;
 - (5) Sum the values of these specific dollar impacts and apply a CMO-specific smoothing factor;
 - (6) Trend forward the weighted dollar amounts to CY 2003;
 - (7) Add an administrative allowance.
 - ii. Additional detail on the calculation of this portion of the CY 2003 rates can be found in the document “Family Care Capitation Rates, CY 2003.”

- c. The composite rates resulting from the blending of these two rating methodologies can be found in Article XVI, CMO Specific Contract Terms (page 104).
- 2. The intermediate rates were developed by trending the CY 2002 intermediate capitation rate forward by one-year.
 - a. Additional detail on the calculation of the CY 2002 rates can be found in the documents “Wisconsin Department of Health and Family Services Family Care 2001 Prospective Rate Development” and “Family Care Capitation Rates, CY 2002.”
 - b. Additional detail on the development of the new trend factor can be found in the document “Family Care Capitation Rates, CY 2003.”

VII. Medicaid CMO Personal Injury Settlements

CMO Name: _____

Name of Recipient and MA ID Number	Date TPL Payment Received	If Available		Payer
		Attorney Name	Amt. Received	
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				

Mail this Form to:
Department of Health and Family Services
CDSD-Contracts Section
One South Pinckney Street, Suite 340
P.O. Box 1379
Madison, WI 53701-1379

VIII. Critical Incidents Protocol

1. Department Role in Relation to Critical Incidents

The Department is responsible for ensuring that CMOs have the capacity to identify and respond to critical incidents in a manner that assures the health and well being of Family Care enrollees. The Department needs documentation of critical incidents in order to:

- a. Ensure the health and well being of Family Care enrollees and others.
- b. Demonstrate that the health and well being of persons served through the Family Care waiver are protected.
- c. Analyze incidents for patterns or trends, monitor the promptness and appropriateness of interventions and provide appropriate feedback and technical assistance to CMOs.

2. CMO Responsibility to Identify and Respond to Critical Incidents

In the Family Care environment, it is the responsibility of the CMO to develop the capacity to detect and respond in an effective manner to critical incidents in the lives of its enrollees. To accomplish this, each CMO must establish procedures, as part of its health and safety plan, to:

- a. Train CMO and contracted provider staff in identifying, responding to and documenting and reporting critical incidents.
- b. Ensure that CMO and contracted provider staff respond appropriately to critical incidents.
- c. Maintain enrollee-specific information in enrollee records about critical incidents, responses by the CMO and any other agency, and enrollee outcomes, and make that information available to the Department upon request.
- d. Ensure CMO management review and analysis of critical incidents to determine whether responses to specific individual incidents were appropriate, and if strategies can be identified for reducing or eliminating some causes of critical incidents.
- e. Develop and maintain effective relationships with other relevant systems (e.g., Adult Protective Services/Elder Abuse).
- f. Share information about critical incidents locally and with the Department in order to continually improve CMO services, systems and enrollee outcomes.

3. Documenting Critical Incidents and CMO Responses

The primary purpose for collecting information about critical incidents and CMO responses is to meet CMO needs to maintain sufficient documentation in order to:

- a. Intervene or take appropriate actions to remove or ameliorate hazards to the health or well being of its members.
- b. When there has been harm to a member, to document the root causes of the harm and what actions were taken to prevent further or future harm.
- c. Document compliance with other statutory requirements, e.g., “Safe Medical Devices Act.”
- d. Continually improve member outcomes, services and case management by analyzing CMO responses to critical incidents, and developing appropriate policies and procedures for responding in a coordinated manner through its case management, network contracting and appeal and grievance systems, and its health and safety and quality improvement plans.
- e. Document compliance with reporting requirements of other relevant systems (e.g., APS, Elder Abuse Reporting System, local law enforcement and courts), and analyze and continually improve the effectiveness of CMO relationships with those systems.

4. CMO Requirements to Report Critical Incident Information

- a. Local Reporting Requirements -- The CMO is responsible for gathering and reporting information related to critical incidents locally:
 - i. Internally to its Governing Board, internal committees, Network Developer and QA/QI Coordinator.
 - ii. Externally to the Local LTC Council.
- b. Family Care Reporting Requirements --The CMO is responsible for gathering and reporting information related to critical incidents to the Department of Health and Family Services, including:
 - i. Reporting unexpected and accidental deaths, and any death potentially due to abuse or neglect as soon as possible after the death, but within forty-eight (48) hours of when the CMO learns of the death.
 - ii. Reporting aggregate information related to critical incidents as part of each CMO’s quarterly narrative report to the Department. Using this venue, CMOs are asked to report aggregate data, not information about specific individuals, incidents or CMO responses.

- iii. Reporting any other enrollee-specific information as needed and requested by the Department.
- iv. All information and reports sent to the Department pursuant to this provision should be sent to:

Beth Hadley
Center for Delivery Systems Development
PO Box 1379
Madison, WI 53701-1379
Phone: (608)267-2912
E-mail: hadlebd@dhfs.state.wi.us

c. Other Reporting Requirements

- i. The CMO and/or its contracted providers is not relieved of other certification, licensing or regulatory requirements for reporting of critical incidents, including requirements to report and investigate deaths or abuse and neglect of residents of certain facilities (e.g., s. 50.034, s. 50.04, HFS 12, 13, 83 and 88).
- ii. Whenever an employee of the CMO or any of its subcontract agencies believes that abuse, material abuse, neglect or self-neglect of an elder person has occurred, the employee shall make a report to the agency designated under s. 46.90.

5. Standardized Reporting Elements in Quarterly Narrative Reports

To be most useful, the aggregate data reported in quarterly narrative reports to the Department will have to be consistent across CMOs. To achieve that consistency, CMOs are to include the following standardized data elements:

- a. Total number of critical incidents.
- b. Number of critical incidents by type:
 - i. Deaths due to abuse, neglect or exploitation.
 - ii. Physical harm due to abuse, neglect or exploitation.
 - iii. Mental/emotional harm due to abuse, neglect or exploitation.
 - iv. Substantial loss in value of the personal or real property of an enrollee due to theft, damage or exploitation.

- c. Number of critical incidents by provider type (i.e. day services, residential provider etc.) where the incident occurred.
- d. Any problems the CMO could not resolve in responding to critical incidents, or technical assistance the CMO would like related to critical incidents.

IX. Performance Improvement Projects

PART 1: Performance Improvement Projects

A. Overview

The main purpose of a Performance Improvement Project is to improve outcomes for the CMO membership overall or a group of members who have similar care and service needs.

Part 2 of this Addendum specifies certain focus areas and member outcomes to be addressed by Performance Improvement Projects. A project shall be based on one of the three focus areas: 1) self-determination and choice, 2) community integration, or 3) health and safety, and on at least one member outcome within the chosen focus area. Within the chosen focus area and outcome, the CMO shall develop specific measurable outcome indicators that will assist in measuring progress towards improving the broad outcome. The focus areas and outcomes are listed in this Addendum under “*Part 2: Performance Improvement Project Options.*”

- **Multiple Focus Areas**
A single Performance Improvement Project may address more than one focus area or more than one outcome, as long as the Performance Improvement Project meets the requirements listed in section (B) below for each focus area and/or outcome selected.
- **Alternative Focus Areas or Outcomes**
If the CMO desires to choose a Performance Improvement Project outside of the options provided in “*PART 2: Performance Improvement PROJECT OPTIONS,*” the CMO shall submit the request to DHFS for review and approval.
- **Collaborative Performance Improvement Projects**
CMOs may satisfy the requirements of this Addendum by participating in collaborative Performance Improvement Projects in conjunction with one or more CMOs.
- **Other Projects.**
In addition to the required project specified above:
 - a. The CMO may initiate its own Performance Improvement Projects; and,
 - b. DHFS may require that the CMO:
 - Conduct particular performance improvement projects that are specific to the CMO; and,
 - Participate annually in at least one statewide QA/QI effort.

B. Performance Improvement Projects: Schedule

1. Following are the required activities and timeline for annual Performance Improvement Projects:
 - a. By the end of the CMO's first contract year:
 - Select topic, identify target population, purpose, identify quality indicators and describe the baseline data collection methodology to be used, (see components "a-e") in section C below).
 - Performance Improvement Projects shall be selected from one of the three different focus areas listed under "*Part 2: CMO Performance Improvement Project Options.*"
 - b. By the end of the CMO's second contract year:
 - The CMO shall complete data collection, analyze and interpret baseline data (see components 'e' and 'f' in section C below) on its year one project.
 - The CMO shall initiate one additional Performance Improvement Project that is not an extension of the project initiated in the previous year. Related to this project, the CMO should select topic, identify target population, purpose, identify quality indicators and describe the baseline data collection methodology to be used, (see components "a-e") in section C below).
 - c. By the end of the CMO's third contract year:
 - Plan and implement improvement activities/interventions, and evaluate whether or not improvement occurred (i.e. repeat data collection, analyze and interpret remeasurement) related to the CMO's project initiated during year one (see components "g" and "h" in section C below.)
 - The CMO shall complete data collection, analyze and interpret baseline data (see components 'e' and 'f' in section C below) related to the CMO's project initiated during year two.
 - d. During the CMO's fourth contract year:
 - Continue implementation of improvement activities, repeat re-measurement, and reevaluation related to project initiated during year one. The CMO shall demonstrate sustained improvement in the project initiated during its first contract year (see components "g" and "h" in section C below).
 - The CMO shall plan and implement improvement activities/interventions, and evaluate whether or not improvement occurred (i.e. repeat data collection, analyze and interpret remeasurement) related to project initiated during year two.

- e. During the CMO's fifth and subsequent contract years:
 - Continue implementation of improvement activities, repeat re-measurement, and reevaluation related to project initiated during year two. The CMO shall demonstrate sustained improvement in the project initiated during its first contract year (see steps "g" and "h" in section C below).
 - The CMO may continue or suspend the project initiated during year one. If the project is suspended, the CMO must provide the Department with a summary report including the CMO's rationale for suspending the project as well as a plan for sustaining improvements made during full implementation of the project and a plan for ongoing monitoring of the project's quality indicators. If the project is suspended, the CMO must initiate a new performance improvement project, beginning with year one components toward full implementation in four years. If the project is continued, the CMO should continue to report results of ongoing data collection, analysis and improvement activities as described in 'd' above.

C. Performance Improvement Projects: Components

1. The following components are required of every Performance Improvement Project. The CMO should include these components when designing, implementing, and evaluating a project. DHFS will evaluate projects conducted by CMOs against these components.
 - a. *Topic*: A topic that is a relevant area of concern or an area of desired improvement for the CMO. The topic shall meet the following criteria:
 - The selected topic should affect a substantial portion of the CMO's members (or a specified sub-group of members) and be related to one of the focus areas and an outcome within a focus area listed in Part 2 of this Addendum.
 - The CMO may select a topic that focuses on conditions or services that occur less frequently in the membership, if there is a pattern of unexpected, adverse outcomes for the condition or service selected.
 - However, the prevalence of a condition or volume of services involved should be sufficient to permit meaningful study.
 - The CMO should select topics that need improvement either because there is significant variation in processes and outcomes within the CMO or the CMO's performance as a whole falls below acceptable benchmarks or norms.
 - Topics should focus on areas that the CMO could change to get better results or outcomes for members.
 - The CMO's providers shall have a formal opportunity to participate in the selection and prioritization of projects.

- b. *Target Population:* A defined target population that includes all members who are involved in the aspect of care or services under the topic.
 - Sampling is acceptable as long as the CMO ensures that individuals included in the samples are randomly assigned and the size is statistically valid.
- c. *Purpose:* The aim or purpose of the project, i.e., the purpose statement should explain the reason for selecting the chosen topic, what interventions are to be improved, and intended improvements in results or member outcomes.
- d. *Quality Indicators:* Defined, objective quality indicators or measures that assist the CMO in monitoring processes and outcomes of care and services for the target population. Quality indicators help the CMO measure progress towards goals. For each project, the CMO shall assess its performance using quality indicators that are:
 - Capable of measuring outcomes such as changes in health status, functional status, and enrollee satisfaction with CMO services, or measuring processes that are associated with outcomes. Examples of indicators are the presence or absence of symptoms, perceived quality of life, perceived quality of care, physical functioning, social role functioning, side effects of treatments, or prevention.
 - Measures of processes are used as a proxy for outcomes only when those processes relate significantly to outcomes.
- e. *Data Collection Plan:* A data collection and analysis plan for determining CMO performance on quality indicators.
 - The CMO shall take steps to ensure that data are uniformly extracted and recorded.
- f. *Data Interpretation:* A summary and an interpretation of the findings, including a description of barriers or gaps in performance and/or improvement opportunities that have been identified from the analysis of the data.
- g. *Improvement Plan:* A plan to improve care and services for the defined target population including:
 - Descriptions and an analysis of the specific process steps that are currently in place for delivering care and services to the defined target population
 - Specific interventions, identification of persons responsible for the interventions, timelines, and a description of how and when the project's effectiveness will be measured.
 - The CMO's interventions shall aim at achieving improvement that is significant and sustained over time.

- A CMO demonstrates significant improvement when it achieves a benchmark level of performance that is defined in advance; or it achieves an increase in the percentage of members who achieve the desired outcome defined by the indicator.
 - Sustained improvement is demonstrated when the CMO shows through continued measurement that its performance gains have endured for at least one year.
- h. *Evaluation:* A review and evaluation of whether or not the new interventions were effective in achieving the desired outcome(s).
- Once the improvement plans have been initiated, data shall be monitored over time for change.
2. The CMO shall report the status and results of each project to DHFS upon request. The report shall include the following:
- a. The topic and the reason the CMO selected the project topic;
 - b. A description of the population or sub-population and the sampling methods used if applicable;
 - c. A description of the aim or purpose of the project;
 - d. The specific quality indicators used to measure CMO performance and how they relate to one or more member outcomes defined in Part 2 of this Addendum;
 - e. A description of the data collection methods used and the procedures through which the CMO has assured that the data are valid and reliable;
 - f. A summary of the findings based on the analysis and interpretation of the data;
 - g. Documentation of the system interventions which were implemented to improve performance;
 - h. The results of the CMO's Performance Improvement Projects. Specifically, whether or not the CMO:
 - Achieved a level of performance that exceeded its own baseline performance; or,
 - Measured a percent improvement in outcomes for the selected indicator(s).

Part 2: CMO Performance Improvement Project Options

Focus Area #1: Self-Determination and Choice

The CMO may choose one of the following member defined outcomes in this category.

Outcome: Members are treated fairly.

Outcome: Members have privacy.

Outcome: Members have personal dignity and respect.

Outcome: Members choose their services.

Outcome: Members choose their daily routine.

Outcome: Members achieve their employment objectives.

Focus Area #2: Community Integration

CMOs may choose one of the following member defined outcomes in the community integration focus area:

Outcome: Members choose where and with whom they live.

Outcome: Members participate in the life of the community.

Outcome: Members remain connected to informal support networks.

Focus Area #3: Health and Safety

CMOs may choose one of the following member defined outcomes in the health and safety focus area:

Outcome: Members are free from abuse and neglect.

Outcome: Members have the best possible health.

Outcome: Members are safe.

Outcome: Members experience continuity and security.